

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12095

12110

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Md.		b. COUNTY	
a a				Md.		Md.		a a	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		10 Annapolis Md.			
RURAL and give nearest town Annapolis				d. STREET ADDRESS		McPherson Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		McPherson Rd.		d. STREET ADDRESS		McPherson Road			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Veronica Agatha Alexander					Nov	2	19	59	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		White	WIDOWED <input type="checkbox"/>	Divorced <input type="checkbox"/>	Feb 5 <sup>th</sup> 1892	67 yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Home		Baltimore Md		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address					
Gordon De Kowzan		Frances Stefanowicz							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
				Gerard Alexander (2)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) D.O.A.  416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease (c)			
DUE TO			DUE TO			INTERVAL BETWEEN ONSET AND DEATH			
						2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>left</u> <u>186</u> to <u>11-2-59</u> , that I last saw the deceased alive on <u>8-31</u> , <u>1959</u> , and that death occurred at <u>6-14</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			DATE SIGNED				
ACTUAL SIGNATURE <u>Frank M. Shifley</u>		M.D. <u>121 Calvert St. 11-3-59</u>							
PHYSICIAN'S NAME (Type) <u>Frank M. Shifley</u>		Cemetery or Crematory <u>St. Mary's Cemt</u>			LOCATION (City, town, or county) <u>Annapolis Md.</u> (State) <u>MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 5-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) <u>Annapolis</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. French</u>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

090

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 6 FilmG252 11-30-59 et  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 12096

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>	c. LENGTH OF STAY IN lb <i>Severna Park</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Saints Nursing Home</i>	e. STREET ADDRESS d. STREET ADDRESS <i>R.F.D.</i>					
3. NAME OF DECEASED (Type or print) <i>Johnna Arnold</i>	4. DATE OF DEATH <i>11/20/1959</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 29 - 1873</i>	9. AGE (in years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife.</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Ludwig Emmerich</i>	14. MOTHER'S MAIDEN NAME <i>Breuning</i>	Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	INFORMANT <i>Mr. William Arnold - 715 Genesee St. - Annapolis, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)</b> <i>Acute Pulmonary Disease</i> <i>Chronic Plethora.</i> <i>Cardiac Failure with</i> <i>Acetate</i>						INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i> <i>1 year</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Not applicable</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <i>Nov 19 1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>While at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Not applicable</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Nov 18 - 59</i> to <i>Nov 20 1959</i> , that I last saw the deceased alive on <i>Nov 19 - 59</i> , and that death occurred on <i>Nov 20 1959</i> at <i>Baltimore</i> , M.D., from the causes and on the date stated above. ADDRESS (Street, City or Town, State) <i>Dr. Joseph Lipsky</i> <i>Physician's Name</i> <i>DR. JOSEPH LIPSKY</i> <i>Physician's Name</i> <i>Brenton, Maryland</i>	DATE SIGNED <i>Nov 20 1959</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/24/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Neff &amp; Sons</i>	ADDRESS <i>Baltimore - 17 N.W.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 24 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

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1950年  
1月

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12149

## CERTIFICATE OF DEATH

12097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Norman Rd.				d. STREET ADDRESS 105 Norman Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HERBERT GRANVILLE	Middle BARNESLEY	Last	4. DATE OF DEATH NOV	Month 8	Day 1959	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1898	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Welder		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christopher Columbus Barnsley		14. MOTHER'S MAIDEN NAME Mary Anderson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ellanora S. Barnsley - 105 Norman Rd.		Address Pasadena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		GENERALIZED CARCINOMATOSIS				INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
153.3 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) CARCINOMA OF SIGMOID.				11 MONTHS	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN., 1959, to SEPT., 1959, that I last saw the deceased alive on SEPT., 1959, and that death occurred at 9 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Arthur Lankford Jr.		M.D.		MOUNTAIN RD.		DATE SIGNED 11-8-59	
PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR.				PASADENA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/59		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Liebner & Sons - Octo 17		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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01-2007110-101484 902700499 STATE QUALITY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12150

## CERTIFICATE OF DEATH

12698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL COUNTY <i>Jessup Md.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
				a. STATE <i>Maryland</i>	b. COUNTY <i>Anne Arundel Co.</i>
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>46 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				<i>Jessup Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>1904 - Jessup Md.</i>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>PAULINE</i>	Middle <i>E.</i>	Last <i>BARONAS</i>	4. DATE OF DEATH <i>Nov. 29 1957</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1865-94</i>	9. AGE (In years lost birthday) <i>94 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during all of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Lettavia</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MIDDLE NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Elizabeth Fabreus Jessup Md.</i>	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>480 X</i>		<i>Bronchopneumonia</i> 1 wk			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) <i>Influenza</i>		160k			
} (c) <i>Gen'l Arteriosclerosis</i>		10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <i>11/25</i> , 19 <i>57</i> , to <i>11/29</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11/27</i> , 19 <i>57</i> , and that death occurred at <i>404 1/2</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>J M Warren</i>		DATE SIGNED <i>11/30/57</i>			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>12/2/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Meadowbrook Memorial Cemetery Md.</i>	22d. LOCATION (City, town, or county) <i>Lanham Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles W. Wheelander 637 Wooly Blv</i>		ADDRESS <i>637 Wooly Blv</i>	24a. REC'D BY REGISTRAR DATE DEC 2 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Davis</i>	

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17 Декабрь - Неделю со следующим этапом работы

Служебно-деловая

10:00-12:00

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## 12151 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>	c. LENGTH OF STAY IN 1b RURAL and give nearest town	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>	d. STREET ADDRESS <b>Box 446</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 446</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CHARLES</b>	First <b>W</b> Middle <b>BEARD</b>	4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>26</b> Year <b>19 59</b>		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 26, 1871</b>	
8. AGE (In years lost birthday) <b>88 yrs.</b>	9. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	10. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co. Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas BEARD</b>	14. MOTHER'S MAIDEN NAME <b>(Unknown) WATERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>217 38 3417</b>	INFORMANT <b>Mr. Thomas W. Beard - Son - Same as # 2</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary artery disease</b> (c) <b>atherosclerosis</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-25</b> , 1959, to <b>11-26</b> , 1959, that I last saw the deceased alive on <b>11-25</b> , 1959, and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Emily H. Wilson</b>		ADDRESS (Street, city or town, state) <b>Lothian, Md.</b> DATE SIGNED <b>11-26-59</b>		
PHYSICIAN'S NAME (Type) <b>Emily Wilson MD</b>		Lothian, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 28, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Hope Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Edgewater, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	24a. REC'D BY REGISTRAR <b>NOV 30 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Calvin S. Krause</b>

MAIL TO ZHAI JUN QI

12102

Parade 2x

X 1  
FOR STATE  
HEALTH DEPT.

Please execute this certificate, writing the word "Pending" in pencil. In Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

Items 18-21 Film 252 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12100

1. PLACE OF DEATH

b. COUNTY

Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Chesterfield Road

First

Middle

3. NAME OF  
DECEASED  
(Type or print)

JOSEPHINE

M.

5. SEX

Female

6. COLOR OR RACE

White

WIDOWED

DIVORCED

BOEHM

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Home

B. DATE OF BIRTH

Mar 18-1895

4. DATE  
OF  
DEATH

November

15, 1959

9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS.  
last birthday Months Days Hours Min.

64 yrs.

13. FATHER'S NAME

Joseph Masek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

S.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Skull fracture

900.0

360EX

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Subdural hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Fell down steps

20c. TIME OF INJURY Month, Day, Year  
Hour  p.m.

11/15 1959

20d. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)  
(County) (State)

Annapolis Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion  
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type) William V. Lovitt, Jr., M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

11/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify)

23. FUNERAL DIRECTOR

ADDRESS

22c. NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

Annapolis

Md

24a. REC'D BY REGISTRAR

DATE NOV 23 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12152

## CERTIFICATE OF DEATH

12101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) M. H. 14500. Me		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sunnyside Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
3. NAME OF DECEASED (Type or print) Blanche B. Boone		d. STREET ADDRESS 1800 E. 1 Box 495	
S. SEX Female		First W.	Middle Initial
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1888
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) yrs. 101
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Snapes Md.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Edmund P. Banks	
14. MOTHER'S MAIDEN NAME Maria Smallwood		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown)	
16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Grafton Boone Jr. - #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cerebral vascular disease - (c) Hypertensive Cerebral Vascular Disease -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 25, 1957</u> to <u>September 18, 1957</u> , that I last saw the deceased alive on <u>Sept 17, 1959</u> , and that death occurred at <u>8:30 A.M.</u> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <u>Felix Grunberg</u>		DATE SIGNED <u>11-19-59</u>	
PHYSICIAN'S NAME (Type) <u>Felix Grunberg</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u> (Sign) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Cons</u>		24a. REC'D. BY REGISTRAR NOV 23 '59	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 7, 9, File #252 11-27-59 et

12102

12153

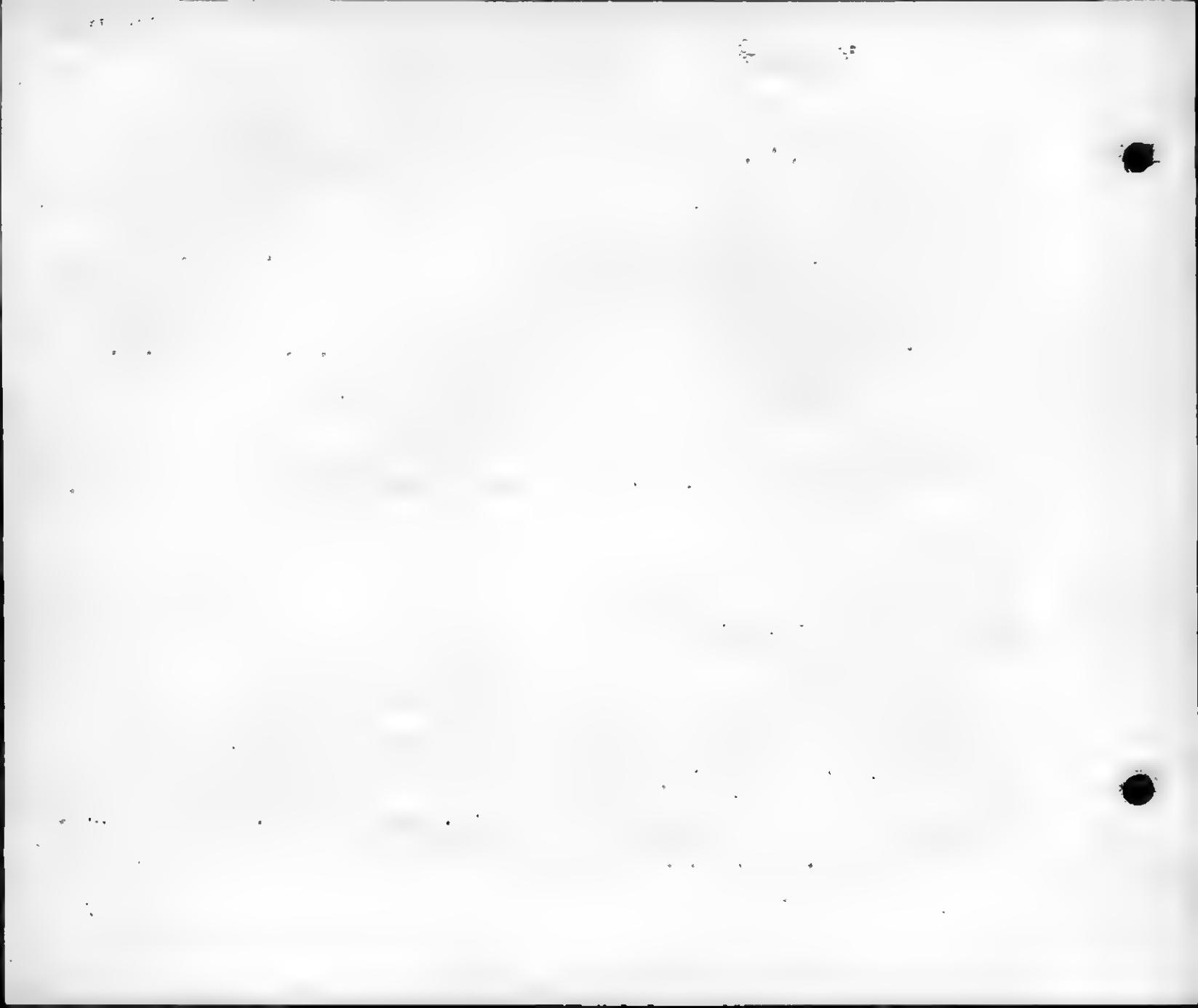
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

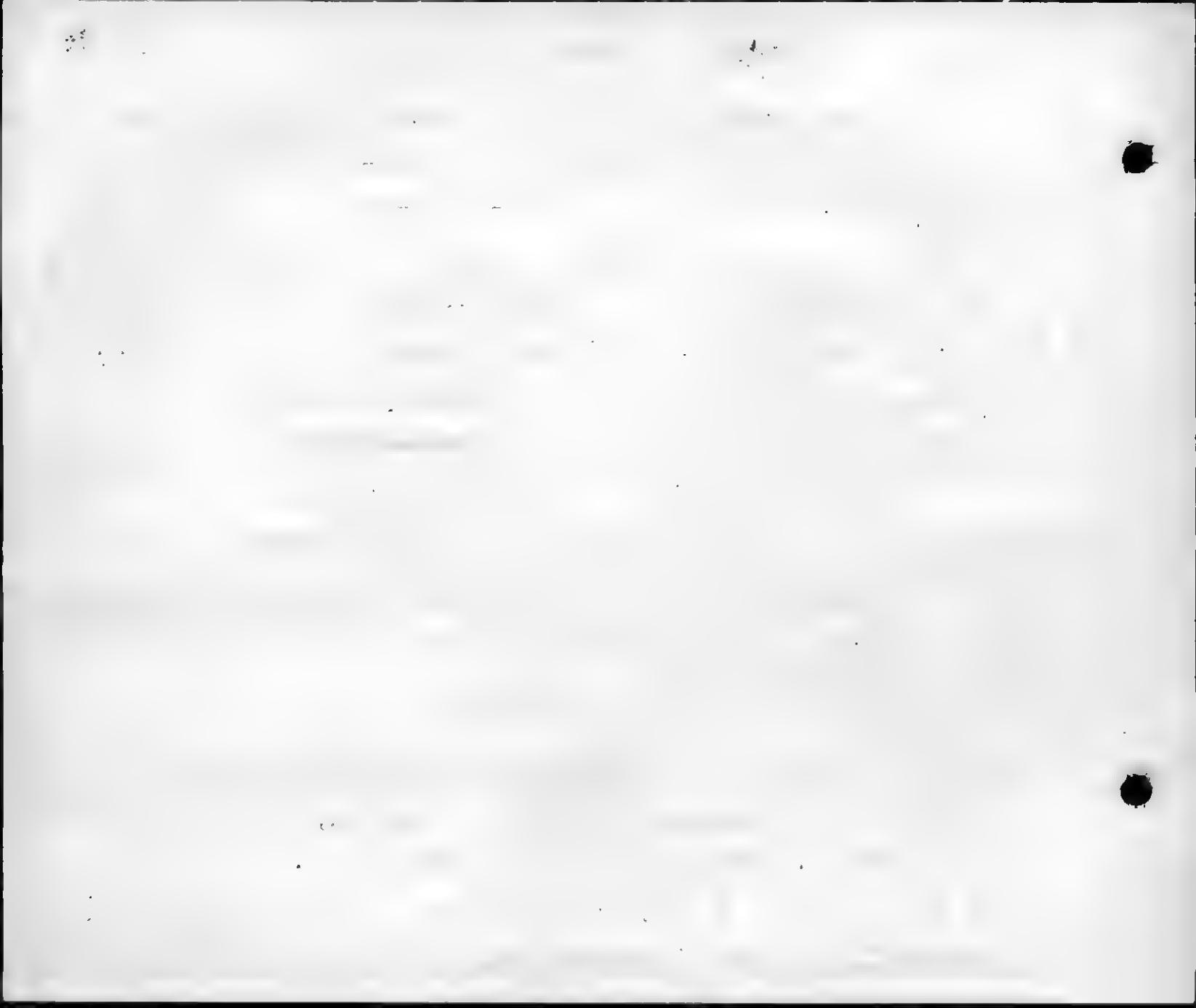
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland Washington 4/1	
3. NAME OF DECEASED (Type or print) Benjamin Bowie		4. DATE DEATH November 15,	Month Year 19 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Washington, D. C.
13. FATHER'S NAME George Bowie		14. MOTHER'S MAIDEN NAME Martha Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	INFORMANT EARLY BOWIE WEST RIVER, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Address INTERVAL BETWEEN ONSET AND DEATH ? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile mental changes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 17, 1957, to November 15, 1959, that I last saw the deceased alive on November 7, 1959, and that death occurred at 4:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 400 N. Carrollton Ave. Baltimore 23, Md.	
ACTUAL SIGNATURE James M. Pair		DATE SIGNED November 16, 1959	
PHYSICIAN'S NAME (Type) James M. Pair, M.D.		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-59	22c. NAME OF CEMETERY OR CREMATORIAL MT. AUBURN
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. JACKSON FUNERAL HOME INC.		ADDRESS NOV 18 '59	24a. REC'D BY REGISTRAR Arthur S. Head
			24b. REGISTRAR'S SIGNATURE



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12103		
12112					CERTIFICATE OF DEATH					Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			Maryland			b. COUNTY
Anne Arundel						Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital						d. STREET ADDRESS Rt-1, Box-195						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year	
Albert			Lucien		BRADY	November			15	19	59	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 4, 1894		65 yrs		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T PAY OFF</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>James R. Brady</b>			14. MOTHER'S MAIDEN NAME <b>Mary Gable</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>6-4-17-1-20-19</b>			INFORMANT Hospital records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>										<b>2 days</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>Arterio-Sclerotic Heart Disease</b>										<b>2 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19												
21. I certify that I attended the deceased from <b>June 1, 1956 to Nov. 15, 1959</b> that I last saw the deceased alive on <b>11-15-1959</b> , and that death occurred at <b>6:15 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>James R. Martin</b> PHYSICIAN'S NAME (Type) <b>James R. Martin</b>										ADDRESS (Street, city or town, state) <b>6 Shaw St., Annapolis, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-17-59</b>			22b. DATE THEREOF <b>11-17-59</b>			22c. NAME OF CEMETERY OR CREMATORIUM <b>ST MARY'S CEM.</b>			22d. LOCATION (City, town, or county) <b>ANNAPOULIS MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SON Annapolis MD.</b>			ADDRESS			24a. REC'D BY REGISTRAR DATE <b>NOV 20 '59</b>			24b. REGISTRAR'S SIGNATURE <b>C. John S. Kean</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12154

## CERTIFICATE OF DEATH

12104

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b. COUNTY Annapolis	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Haven		c. LENGTH OF STAY IN 1b 1 year -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manoa Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beauford Middle Brock's Last		4. DATE OF DEATH 11/16/1959	
5. SEX Mr. 6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 9-05-1879 9. AGE (In years at time of death) 80 yrs.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Clark C. W.		14. MOTHER'S MAIDEN NAME Mrs. Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 212-18-5555 17. INFORMANT Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 222x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO		General Troubles. Generalized arteriosclerosis	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS ANATOMICAL EXAMINATION PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-26-1958 to 11/16/59, that I last saw the deceased alive on 10-22-1959, and that death occurred at 1339 M., from the causes and on the date stated above.		ACTUAL SIGNATURE Fehling Svartberg M.D. ADDRESS (Street, city or town, state) P.O. Box 837 Odenton, Md. DATE SIGNED 11/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/16/1959		22b. DATE THEREOF 11/16/1959	
22c. NAME OF CEMETERY OR CREMATOR Y Hillside Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hillside Cemetery, Inc. 108th Street & 11th Avenue		ADDRESS Nov 23 '59	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE C. H. S. Kline	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12105

12155

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Anne Arundel MARYLAND		Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 year 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Brooks
4. DATE OF DEATH		Month November	Day 13 Year 1959
5. SEX	6. COLOR OF RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
M.	C.	5-16-1995	9. AGE (In years lost birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
LABORER		NONE	
10c. BIRTHPLACE (State or foreign country)		11. MOTHER'S MAIDEN NAME	
BALTO. Md.		MARY ROBINSON Address 619 W. LYNCHBURG ST.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
RICHARD BROOKS		LYNNIE WILLIAMS MULBERRY S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
UNKNOWN			
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
Lorraine Brooks		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
420.1		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Hypertensive Cardio-Vascular Disease	
DUE TO		(c) Progressive Neuromuscular weakness	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ————— 19 p. m. —————		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-81 1958, to 11-1 1959, that I last saw the deceased alive on 10-25 1959, and that death occurred at 7-A- M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DC. 00000 DATE SIGNED 11/1/59	
ACTUAL SIGNATURE Lorraine Brooks M.D.		PHYSICIAN'S NAME (Type) Febus Grubbs	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial 11-4-59		22c. NAME OF CEMETERY OR CREMATORIAL M.F. AUBURN BALTIMORE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		22d. LOCATION (City, town, or county) (State)	
William A. JACKSON INC.		24a. REC'D BY REGISTRAR DATE NOV 5 '59	
914 PENN AVE.		24b. REGISTRAR'S SIGNATURE Charles Gathman	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12113

## CERTIFICATE OF DEATH

Reg. Dist. No.

12106

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	c. LENGTH OF STAY IN lb 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Annapolis		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Rt-1, Box-69		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Mildred	Middle Elenore	Last BUECHLING	4. DATE OF DEATH 11 13 1959
5. SEX <input checked="" type="checkbox"/> F	6. COLOR OR RACE <input checked="" type="checkbox"/> W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-07	9. AGE (In years lost birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Ohio	12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Harry A. Covey		14. MOTHER'S MAIDEN NAME Gertrude West		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO 214 144 959	17. INFORMANT Charles Buechling	Address Glen Isle Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chronic pulmonary fibrosis		??		
(c)				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 1957, to Nov. 1957, that I last saw the deceased alive on Nov. 13, 1959, and that death occurred at 12:35 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Edward S. Beck, M.D., 4 Southgate One, Annapolis, Md. DATE SIGNED 11/13/59		
ACTUAL SIGNATURE Edward S. Beck				
PHYSICIAN'S NAME (Type) Burial		22b. DATE THEREOF Nov 16, 1959		
22c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons		ADDRESS Hyattsville Md.		
24a. REC'D BY REGISTRAR NOV 17 '59		24b. REGISTRAR'S SIGNATURE Clinton & Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12156 CERTIFICATE OF DEATH**

12107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN lb 1 yr. - 8 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address or INSTITUTION District Training School, Laurel, Md.)		STREET ADDRESS 1233 Walter Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First Shirley	Middle Campbell	4. DATE OF DEATH Nov. 5, 1959	Month Nov.	Day 5	Year 1959
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1952	9. AGE (In years lost/birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Willie Campbell	14. MOTHER'S MAIDEN NAME Myrtle Redfearn Campbell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -	16. SOCIAL SECURITY NO. -	17. INFORMANT Children's Center	Address Laurel, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mental retardation - post-birth subdural hematoma (c) Convulsive disorder		Fro m birth

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) ---		
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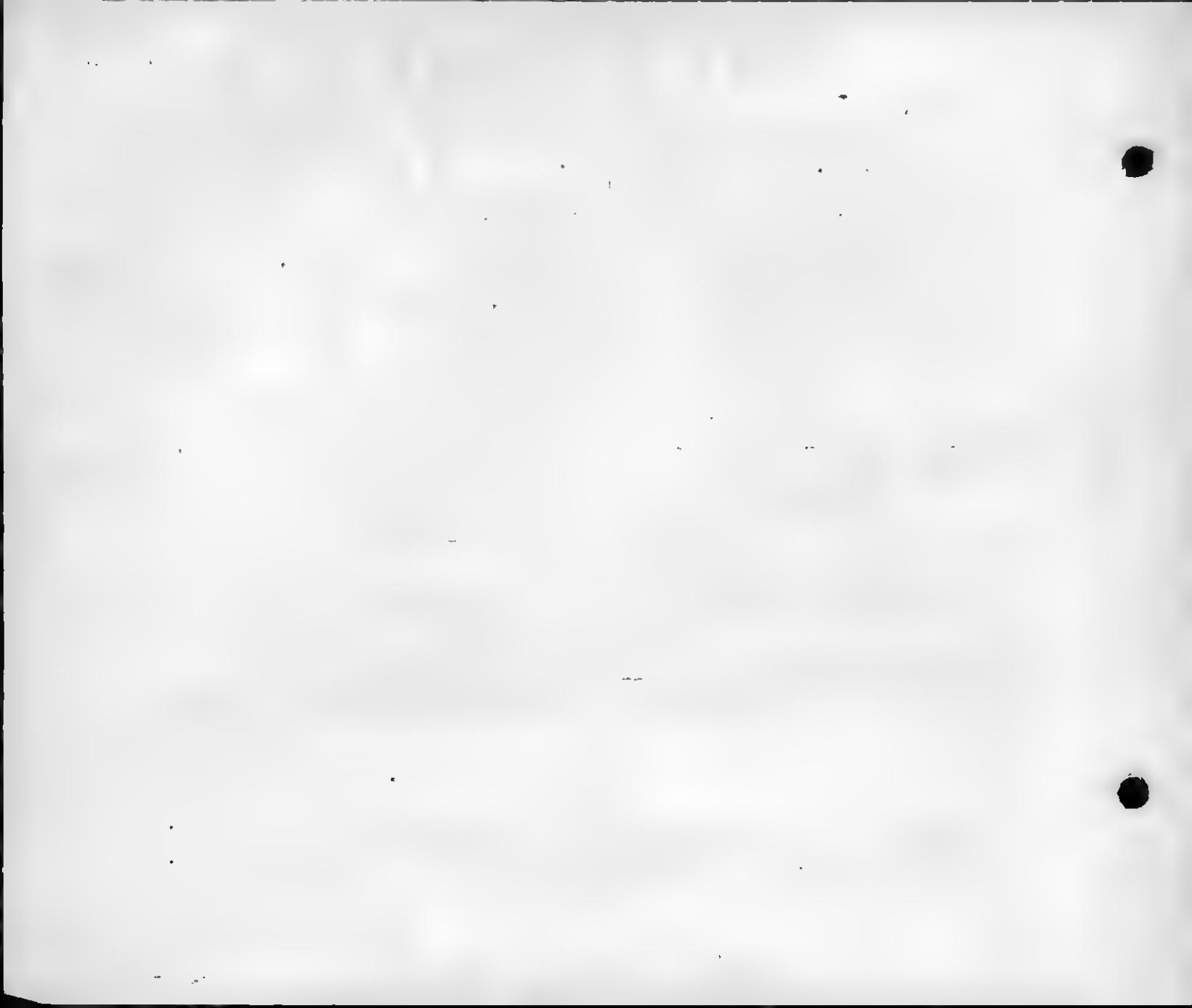
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Laurel, Md.	(County) Anne Arundel Co.	(State) Md.
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21. I certify that I attended the deceased from 2/14/58, 19, to 11/5/59, 19, that I last saw the deceased alive on 11/5/59, 19, and that death occurred at 5:00 p.M., from the causes and on the date stated above.					
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ACTUAL SIGNATURE <i>James E. Boyland</i>	ADDRESS M.D. Children's Center, Laurel, Md.	DATE SIGNED 11/6/59
PHYSICIAN'S NAME (Type) James E. Boyland M.D.	ADDRESS Children's Center, Laurel, Md. 11/6/59	

22a. BURIAL, CREMATION, RE-CREMATION (Specify) Cremation	22b. DATE THEREOF 11/9/59	22c. NAME OF CEMETERY OR CREMATORIAL DTS Cemetery	22d. LOCATION (City, town, or county) Laurel, Md.	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Roone, Jr.</i>	ADDRESS DTS Laurel, Md.	24a. REC'D BY REGISTRAR NOV 12 '59	24b. REGISTRAR'S SIGNATURE <i>John J. Roone, Jr.</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12189

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
ANNE ARUNDEL MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
ANNAPOLIS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
AA. GENERAL HOSPT.		RURAL ANNAPOLIS	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DEFENSE HIGHWAY			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
ARTHUR	ROLAND	CARR	CARR
4. DATE OF DEATH	Month	Day	Year
Nov	22		1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	SEPT 24 1902
8. AGE (In years last birthday)	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	11. Hours
57 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
FARM SUPPLY STORE		MERCHANT	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN A. CARR		IRENE KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT MARY E. CARR #2	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> 466 X DUE TO <i>Obstruction of pulmonary veins - lung extremely</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>Severe</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Taylor</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>Nov 13/59</i>
EXAMINER'S NAME (Type) <i>John Taylor</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
	11-25-1959	EDWARDS CHAPEL	ANNAPOLIS MD
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JOHN M. TAYLOR SON ANNAPOLIS MD.		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12157

## CERTIFICATE OF DEATH

Reg. Dist. No.

12110

PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs. 11 mo. 9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>409 Durham Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Lewis</b>	Middle <b>(Lewis)</b>	Last <b>Carter</b>	4. DATE OF DEATH	Month <b>11</b>	Day <b>23</b>	Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Aug. 28, 1903</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Junk Hauler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joe Carter</b>				14. MOTHER'S MAIDEN NAME <b>Ida</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART F. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Diabetes Mellitus - Gangrene both legs</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c TIME OF INJURY Month, Day, Year Hour a. m. <b>10</b> p. m. <b>10</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/14</b> , 19 <b>55</b> , to <b>11/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/23</b> , 19 <b>59</b> , and that death occurred at <b>6:30P.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	DATE SIGNED <b>11/24/59</b>
ACTUAL SIGNATURE <i>Hildegard Heard Reissman, M.D.</i>								Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>								Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary Cemetery</b>		22d. LOCATION (City, town, or county) <b>Anne Arundel Co.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. Latta Jr.</i>		ADDRESS <b>Boyce N. Central Ave.</b>		24a. REC'D. BY REGISTRAR DATE <b>NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Cathleen S. Krause</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12115

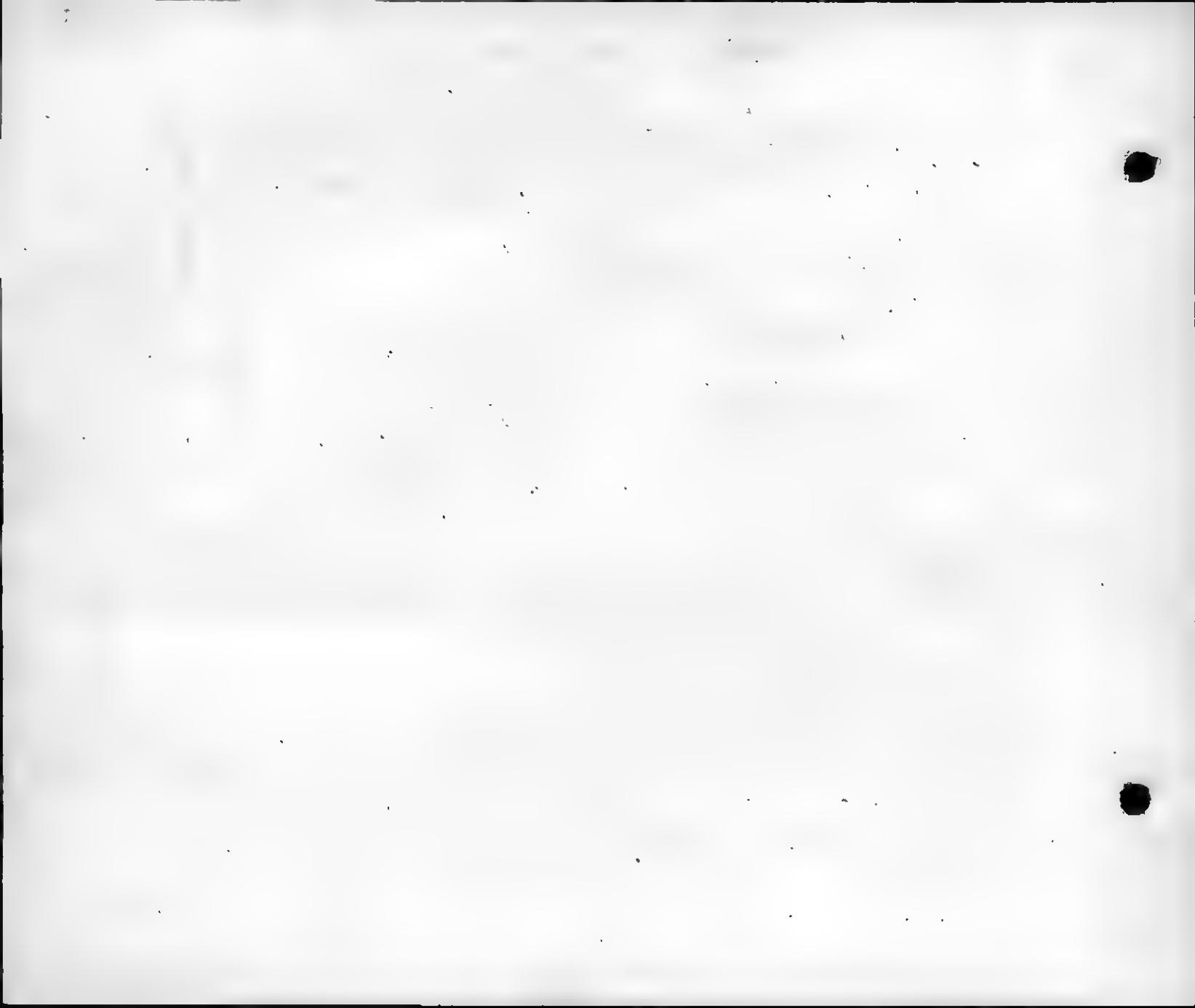
## CERTIFICATE OF DEATH

12111

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE	
<i>A.A. County Maryland</i>		<i>Maryland A.A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>Annapolis Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>102 S. Villa Ave</i>	<i>102 S. Villa Ave</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Bessie A. Chambers</i>			
4. DATE OF DEATH	Month	Day	Year
	11	19	1959
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Female Col</i>			<i>3-14-1922 57 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>		<i>Maryland</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Nelson Bellman</i>	<i>Leatha Jarvis</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO	INFORMANT	Address
		<i>John W. Chambers 102 S. Villa Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<i>153.8</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>6-8-59</i> , 19, to <i>11-19-59</i> , 19, that I last saw the deceased alive on <i>11-18-59</i> , 19, and that death occurred at <i>9:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A.T. Allen</i>		ADDRESS (Street, city or town, state) <i>6 &amp; Cathedral St Annapolis Md.</i>	
PHYSICIAN'S NAME (Type) <i>A.T. Allen</i>		DATE SIGNED <i>11-20-59</i>	
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>11-22-1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Brewer Hill</i>		<i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>William Reeseth 108 Wash. St. Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12158

## CERTIFICATE OF DEATH

Reg. Dist. No.

12112

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>44 yr. 9mo. 11</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Anne Arundel Co.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <b>UNKNOWN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Emma</b>		Middle <b>Colbert</b>		4. DATE OF DEATH <b>Nov. 30 1959</b>		Month Day Year			
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881</b>	9. AGE (In years lost birthday) yrs. <b>78</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Colbert</b>			14. MOTHER'S MAIDEN NAME <b>Emmally Duckett</b>			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x</b> DUE TO <b>Acute Cardiac Failure</b> INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertensive and Arteriosclerotic Cardiovascular Disease</b> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Doy, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb. 17, 1956</b> , to <b>Nov. 30, 1959</b> , that I last saw the deceased alive on <b>Nov. 30, 1959</b> , and that death occurred at <b>8:37 AM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED									
ACTUAL SIGNATURE <b>Ludwig Benedict</b> M.D.									
PHYSICIAN'S NAME (Type) <b>Dr. Ludwig Benedict, M.D.</b> Crownsville, Md.									
22d. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		22b. DATE THEREOF <b>12-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Reese Jr.</b>		ADDRESS <b>Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 2 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12116

## CERTIFICATE OF DEATH

Reg. Dist. No.

12113

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) o. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
3. NAME OF DECEASED (Type or print) <b>James B</b>		4. DATE OF DEATH <b>COLBURN, Sr.</b> November 24, 1959	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		9. AGE (In years last birthday) <b>71 yrs.</b>	
13. FATHER'S NAME <b>Milton Colburn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Riggel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <i>Central nervous system infection</i>		INFORMANT <b>Mrs Esther Hall Colburn- Wife same as # 2</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Concussion causing meningo</i>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1959, to <b>Nov. 24</b> , 1959, that I last saw the deceased alive on <b>Nov. 24</b> , 1959, and that death occurred <b>10:10 P.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>11/25/59</b>			
ACTUAL SIGNATURE <b>John L. Hedeman</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>		Ann Arbor, Mich.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 27, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Ann Arbor, Mich.</b>	
24a. REC'D BY REGISTRAR <b>Arthur S. Hansen</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hansen</b>	
DATE <b>NOV 30 '59</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12159

Item 14 Film G253 12-24-59 et  
CERTIFICATE OF DEATH

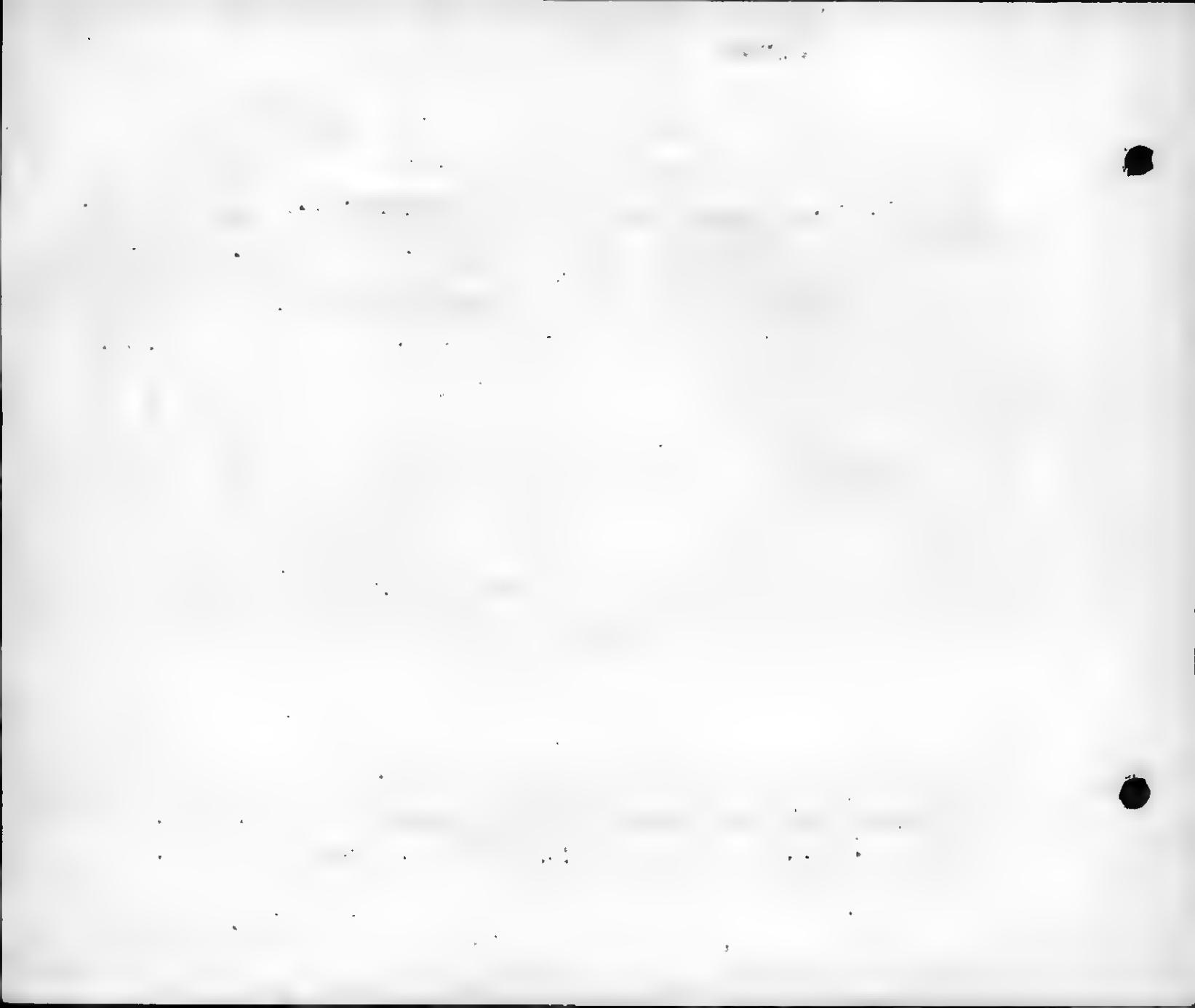
12114

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snowhill</b>		d. STREET ADDRESS <b>204 Collins Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Irene</b>		First	Middle	Last	4. DATE OF DEATH <b>Collick</b>	Month <b>11</b>	Day <b>16</b>	Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1917</b>		9. AGE (In years lost birthday) <b>42</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Year Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Collick</b>		14. MOTHER'S MAIDEN NAME <b>Lillian (Unknown)</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>									
DUE TO <b>352X</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Decubitus ulcers</b>									
DUE TO (c) <b>Spastic hemiparesis, disorganized convulsions</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) - - - - -							
20c. TIME OF INJURY Month, Day, Year Hour a.m. - - 19 p.m. - - -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) - - - - -		(County) - - - - -	(State) - - - - -
21. I certify that I attended the deceased from <b>10/27, 1959</b> , to <b>11/16, 1959</b> that I last saw the deceased alive on <b>11/16, 1959</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Hildegard Heard Reissman, M.D.</b>									DATE SIGNED <b>11/16/59</b>
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>		M.D. <b>Crownsville State Hospital, Md.</b> 11/16/59							
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>		Crownsville State Hospital, Md. 11/16/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 11/19/59		22b. DATE THEREOF <b>11/19/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Elmwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Dorsey Hall, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hinch 43-45 North West</b>		ADDRESS <b>Annapolis</b>		24a. REC'D. BY REGISTRAR DATE <b>NOV 19 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Turner</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12160

## CERTIFICATE OF DEATH

Reg. Dist. No.

12115

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena (Md)</i>		c. LENGTH OF STAY IN 1b <i>23 yrs +</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Poplar Ridge Road</i>		d. STREET ADDRESS <i>Poplar Ridge Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHRISTIAN ANDREW</b>		First	Middle	(Roch)	4. DATE OF DEATH <b>NOV. 17 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 Sept 1890</b>	9. AGE (In years last birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b> IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fisherman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Salt Corp.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Christian Koch</i>		14. MOTHER'S MAIDEN NAME <i>Lena Elbers</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-3977</b>		17. INFORMANT <b>Arthur Lankford Jr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b>		DUE TO { Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause lost (b) <b>GENERALIZED CARCINOMATOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>	
		DUE TO (c) <b>CARCINOMA RECTUM</b>		6 MONTHS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUGUST</b> , 19 <b>59</b> , to <b>NOVEMBER 15, 1959</b> , that I last saw the deceased alive on <b>NOVEMBER 15, 1959</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <b>11-17-59</b>	
ACTUAL SIGNATURE <i>Arthur Lankford Jr.</i>		M.D. <b>MOUNTAIN RD.</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b>		PASADENA, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 20 Nov. 1959</b>		22b. DATE THEREOF <b>20 Nov. 1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Montgomery County</b>	
22d. LOCATION (City, town, or county) <b>Towson, Md.</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. D. Brightman</i>		ADDRESS <i>Glen Burnie, Md.</i>		24d. REC'D BY REGISTRAR DATE <b>NOV 20 1959</b>	
				24e. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12116

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>New Jersey</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>		c. LENGTH OF STAY IN lb <b>15 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>810 Riverside Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cape May</b>	
3. NAME OF -DECEASED (Type or print) <b>Steven Michael Dadez</b>		First <b>Steven</b>	Middle <b>Michael</b>
		Last <b>Dadez</b>	4. DATE OF DEATH <b>November 14th.</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>Hawaiian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>7/26/59</b>		9. AGE (In years last birthday) <b>3 yrs</b>	10. IF UNDER 1 YEAR <b>3 mos</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Cape May Court House, N.J.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ricarte Dadez</b>	
14. MOTHER'S MAIDEN NAME <b>Dorothy E. Koutz</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr and Mrs R. Dadez (parents.)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
9240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Baby was sleeping on his belly, his head covered with a blanket.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9 A.M.</b> 11/14/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) <b>In his own carriage. 810 Riverside Rd. A.A. Md.</b>
20f. (City or town) <b>Baltimore, Md.</b>		(County) <b>Baltimore Co.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED <b>11/14/59</b>	
NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-16-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood Cem.</b>
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C Miller Inc. 2431 E. Oliver St.</i>		24a. REC'D BY REGISTRAR <b>NOV 17 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Carroll &amp; Kraus</i>
		ADDRESS <b>J9VVVVVVXVV</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12117

12117

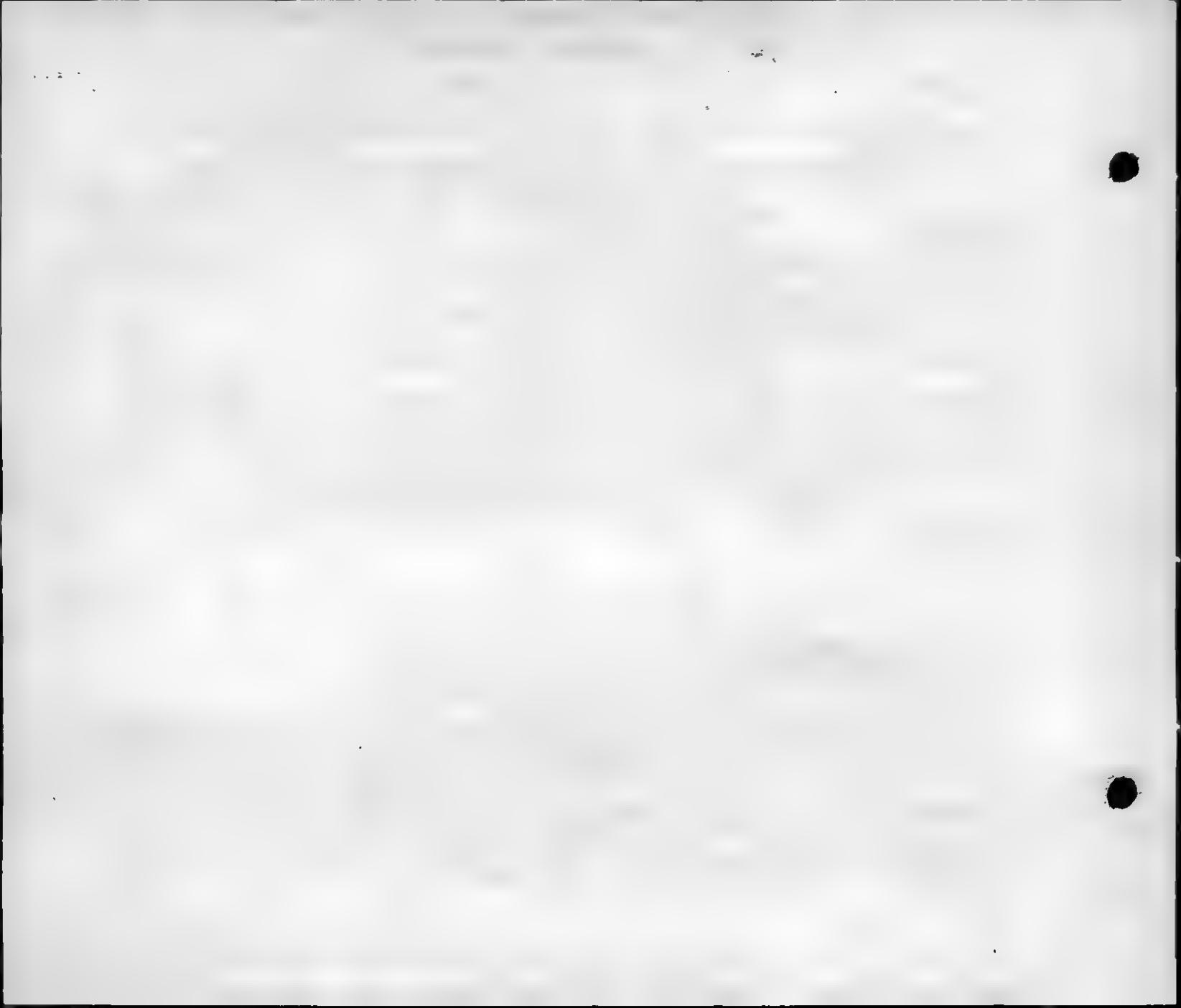
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
a. A.A.		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Annapolis		a. A.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1418 Park View Ave	1418 Park View Ave		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Margaret Ann Williams Daniel			
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/>	Apr. 19 <sup>th</sup> 1834
8. AGE (In years last birthday) yrs.		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Hours
85		Months	Days
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
School Teacher Ret.		Public School	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Frostburg Md		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James D. Williams		Leviah Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
		17. INFORMANT	
		Miss Leviah Daniel	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
422.1 Acute dilatation of the heart			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) Arteriosclerotic Cardio Vascular			
DUE TO			
(c) Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Gangrene to the left foot			
INTERVAL BETWEEN ONSET AND DEATH Immediata			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1954 to Nov. 14, 1957, that I last saw the deceased alive on Nov. 14, 1957, and that death occurred at S. 24th M., from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED 12/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		11-17-59	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Frostburg Memorial Pk		Frostburg	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
John M. Taylor Sms		24b. REGISTRAR'S SIGNATURE	
Annapolis Md		Doris S. Kress	
VS A15 (4) 15M 9/55		DATE NOV 20 '59	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 12 filing 252 11-24-59 et 12162 CERTIFICATE OF DEATH												Reg. Dist. No. 12118	
1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL <i>Millersville, Md</i>				MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Anne Arundel Co. 4 WKS				c. LENGTH OF STAY IN lb		d. STATE <i>Sherman</i>		b. COUNTY <i>AA</i>			
c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		<i>St. Mary's Hospital</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>Quarterfield Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year				
S. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH		8. AGE (In years last birthday) <i>85</i>	9. IF UNDER 1 YEAR Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES (es. no. or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>acute lysis from surgery</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last <i>422.1</i>		(b) DUE TO <i>Gardia lysis before</i>		2 years									
(c) DUE TO <i>prostate hyper trophy</i>		3 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senility</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at play <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>				
21. I certify that I attended the deceased from alive on <i>Nov 15 1959</i> , and that death occurred <i>Nov 16 1959</i> .		M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>100 E. Pratt St., Baltimore, Md.</i>		DATE SIGNED <i>11/16/59</i>							
ACTUAL SIGNATURE <i>J. Kelly Murphy, M.D.</i>		PHYSICIAN'S NAME (Type) <i>J. Kelly Murphy, M.D.</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/19/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Ckn Haven Mem.</i>	22d. LOCATION (City, town, or county) <i>Glen Burnie, Md</i>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping &amp; Kierney, Bkn Burnie, Md</i>		ADDRESS <i>88 Kierney</i>		24a. REC'D BY REGISTRAR <i>John S. Evans</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Evans</i>							
VS A1s (4) 1SM 9/58		DATE <i>NOV 19 '59</i>											

W. H. - 2000. *But I have still  
had it from Mr. W. - and you will see it in  
Mr. H. -* *He is a good man.*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12119

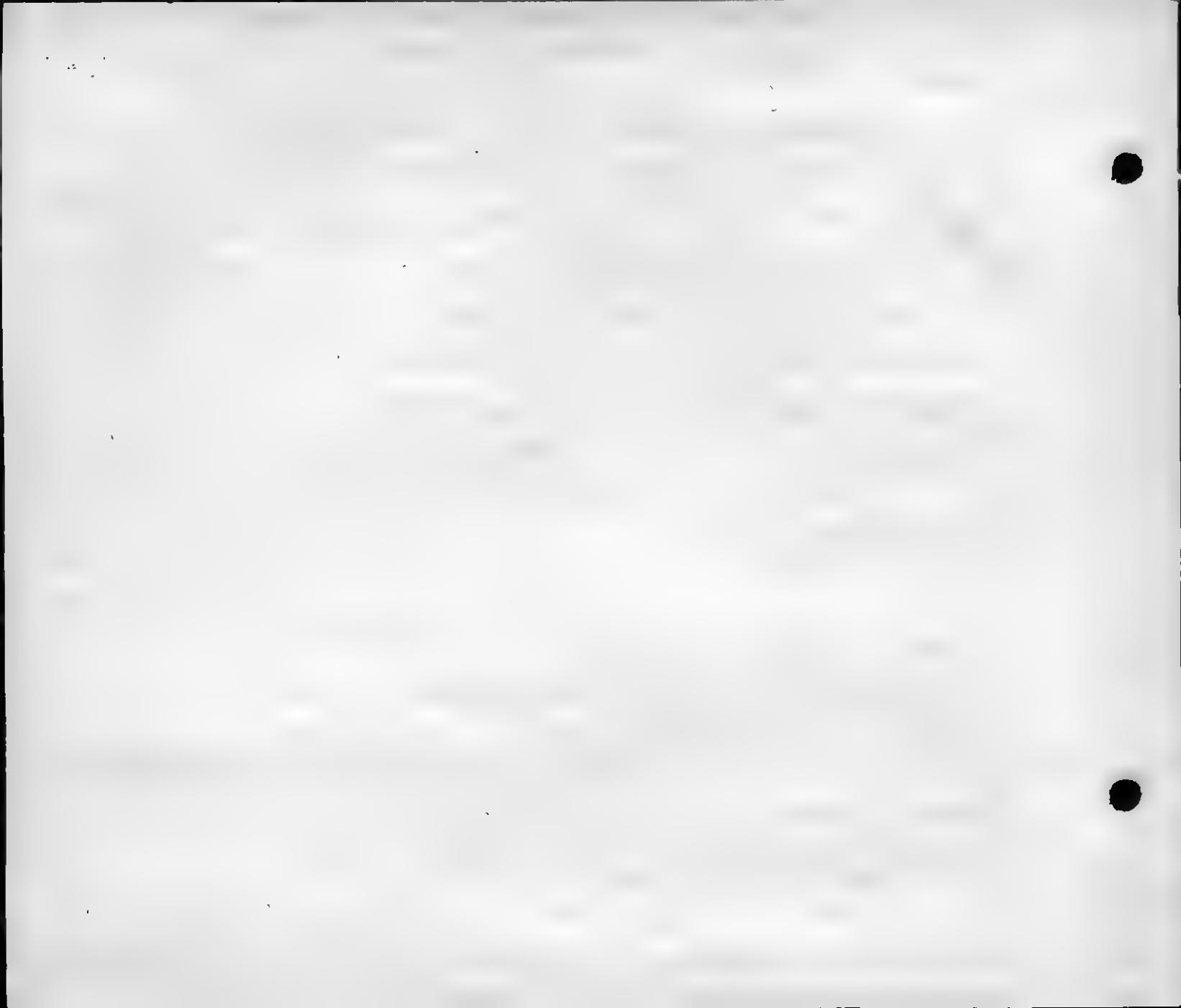
12118

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE	
<i>ANNE ARUNDEL MARYLAND</i>		b. COUNTY <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HOMECOMING CONVALESCENT HOME</i>		d. STREET ADDRESS <i>108 Monticello Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>CATHERINE</i>	Middle <i>HAASE</i>
4. DATE OF DEATH		Month <i>NOV</i>	Day <i>23</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
FEMALE		WHITE	8. DATE OF BIRTH <i>MAY 4, 1880</i>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months <i>79</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	11. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>unknown</i>	
14. MOTHER'S MAIDEN NAME <i>unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no volunteer) <i>No</i>	
16. SOCIAL SECURITY NO <i>██</i>		17. INFORMANT <i>BERNARD C. HOFF 106 #2d</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
19. DUE TO <i>BRONCHOPNEUMONIA</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
20. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Nov 23 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>ANNAPOLIS</i> (County) <i>MARYLAND</i> (State) <i>M.D.</i>	
21. I certify that I attended the deceased from <i>Nov 23 1959</i> , that I last saw the deceased alive on <i>Nov 23 1959</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward C. Beck</i>		ADDRESS (Street, city or town, state) <i>4 Southgate Ave Annapolis Md</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>11/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Nov 26, 1959</i>		22b. DATE THEREOF <i>Nov 26, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>HILLCREST MEM.</i>		22d. LOCATION (City, town, or county) <i>ANNAPOLIS MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR SON ANNAPOULIS MD.</i>		24a. ADDRESS <i>12118</i>	
		24b. REC'D BY REGISTRAR <i>NOV 27 '59</i>	
		24c. REGISTRAR'S SIGNATURE <i>C. M. S. KANE</i>	



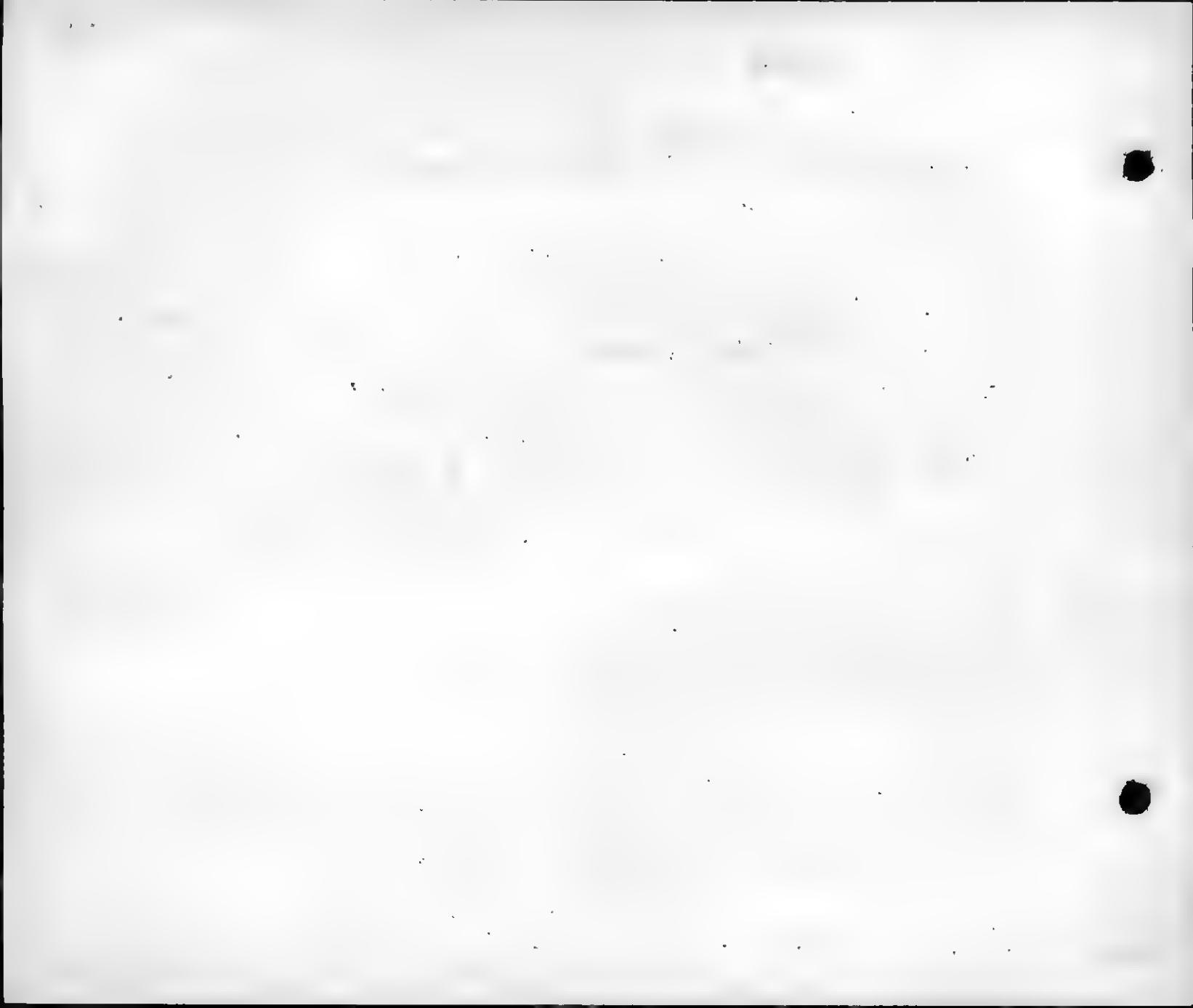
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12120

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>a a.</i>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Md.</i>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>82 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Thomas Franklin DEALE</i>		First <i>Franklin</i>	Middle <i></i>		
Last <i>DEALE</i>		Last <i></i>	4. DATE OF DEATH <i>Nov 1 1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 1 1877</i>		
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Waterman Railway</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>DEALE, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i></i>		
13. FATHER'S NAME <i>JAMES DEALE</i>	14. MOTHER'S MAIDEN NAME <i>ELIZABETH CRUTCHLEY</i>	INFORMANT <i>Mrs Margaret A. Phillips, Dealer, b/d</i>	Address <i></i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Venous Accident</i> DUE TO <i>artery occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>DEALE</i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>10-30 AM</i> to <i>1 PM</i> , <i>1959</i> , that I last saw the deceased alive on <i>14-1 PM</i> , <i>1959</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above					
ACTUAL SIGNATURE <i>Frank M. Shipley</i>	ADDRESS (Street, city or town, state) <i>M.D. 121 Cathedral St. Annapolis, Md.</i>		DATE SIGNED <i>11-1-59</i>		
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>					
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-3-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>DEALE Cemetery</i>	22d. LOCATION (City, town, or county) <i>DEALE</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Serviced Hardisty Galiville b/d</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>NOV 4 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Albert S. Evans</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12163

## CERTIFICATE OF DEATH

Reg. Dist. No.

12121

1. PLACE OF DEATH a. COUNTY <i>a.a.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>a.a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wellesmere Shores</i>		c. LENGTH OF STAY IN 1b <i>1 B. &amp; D. Annapolis Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>1 B. &amp; D. Annapolis Md</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>P.</i>	Last <i>Drake Sr.</i>
4. DATE OF DEATH	Month <i>11</i>	Day <i>21</i>	Year <i>19 529</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26 1904</i>
9. AGE (In years lost birthday) <i>53 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working-life even if retired) <i>Guard at 446 jail</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Guard</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>WALTER W. DRAKE</i>	14. MOTHER'S MAIDEN NAME <i>Margie Wilkerson</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO (If yes, give war or date of service)	17. INFORMANT <i>Joseph P. Drake Jr. (2)</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
INTERVAL BETWEEN ONSET AND DEATH <i>0-11.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>121 Calverton Rd</i>
20f. (City or town) <i>Calverton</i>	(County) <i>Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>	ADDRESS (Street, city or town, state) <i>121 Calverton Rd</i>		
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley Annapolis Md</i>	DATE SIGNED <i>11-25-51</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov 24 59</i>	22b. DATE THEREOF <i>Nov 24 59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>77 Lincoln Cemetery Anne Arundel Co</i>	22d. LOCATION (City, town, or county) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gavin M. Taylor Son Annapolis Md</i>	ADDRESS <i>121 Calverton Rd</i>	24a. REC'D BY REGISTRAR <i>NOV 27 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Gavin M. Taylor</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12164

## CERTIFICATE OF DEATH

Reg. Dist. No.

12122

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>5 yrs. 11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b>		d. STREET ADDRESS <b>Unknown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>John</b>		First	Middle	Last	4. DATE OF DEATH <b>11</b>	Month	Day	Year <b>10 19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>1893</b>	9. AGE (In years last birthday) <b>66 yrs</b>	IF UNDER 1 YEAR Months <b>6</b>		IF UNDER 24 HRS Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b KIND OF BUSINESS OR INDUSTRY -----		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>David Duckett</b>		14 MOTHER'S MAIDEN NAME <b>Julia Ann</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
Acute hemorrhagic pancreatitis Thrombosis of pancreatic veins								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity, Generalized arteriosclerosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> ----- p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) -----		20f. (City or town) -----		(County) <b>-----</b> (State) <b>-----</b>
21. I certify that I attended the deceased from <b>10/29</b> , 19 <b>54</b> , to <b>11/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/10</b> , 19 <b>59</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>11/10/59</b>								
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b> M.D. <b>Crownsville State Hospital, Md. 11/10/59</b>								
PHYSICIAN'S NAME (Type)		Crownsville State Hospital, Md. 11/10/59						
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial Nov. 14, 1959</b>		22b. DATE THEREOF <b>Nov. 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Bucco Chapel</b>		22d. LOCATION (City, town or county) <b>Waldorf</b> (Md.) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Fowle Horn</b>		ADDRESS <b>North Fowle Horn Waldorf</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Krause</b>		

W. H. Clegg  
Clegg record file 41-11.

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12123

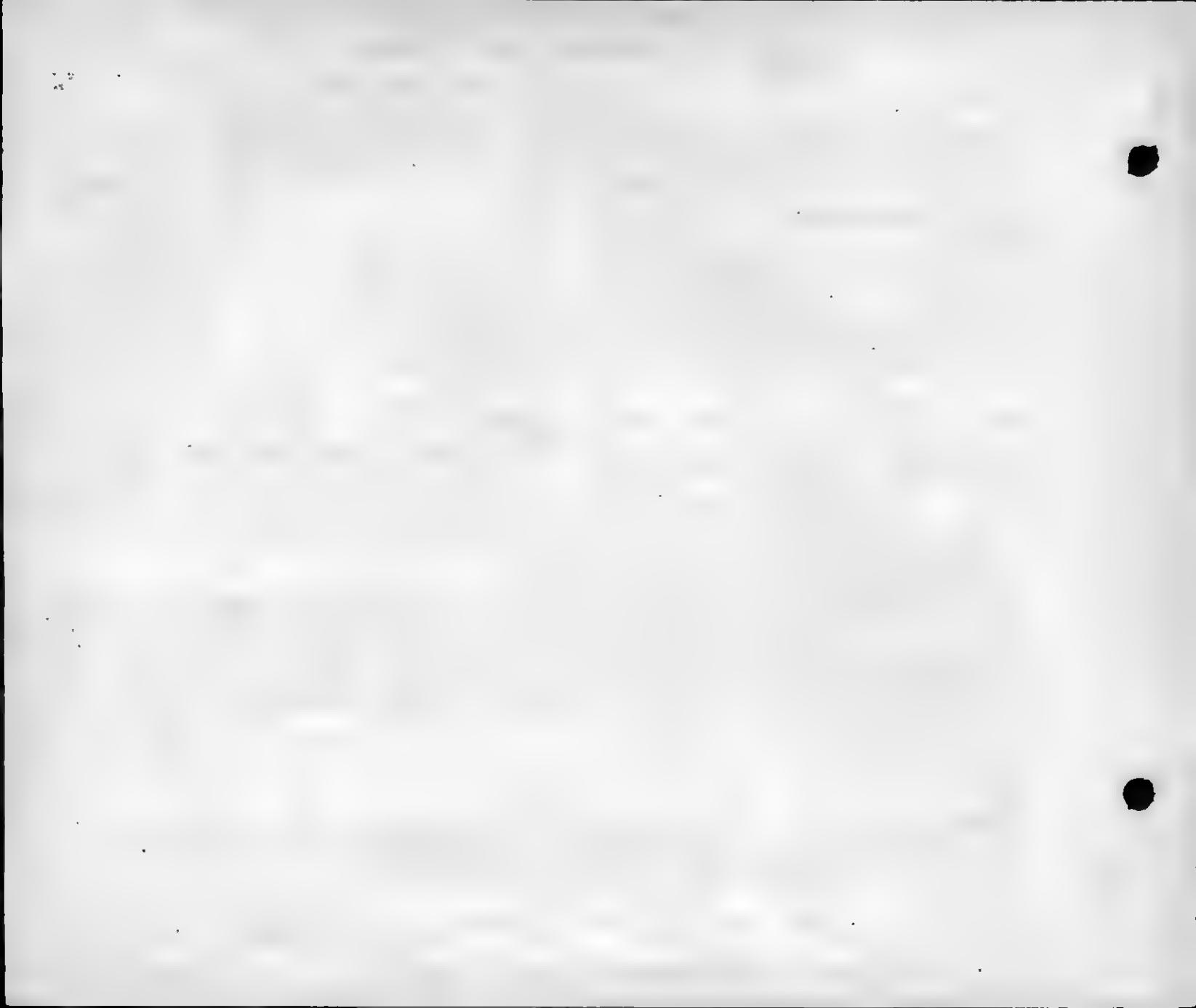
Reg. Dist. No.

12165

1. PLACE OF DEATH a. COUNTY <i>A.A. do.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>M.D.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn Grove Annapolis Md 44yr S.</b>		c. LENGTH OF STAY IN MD <i>4 yr s.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Severn Grove</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Elizabeth</i>	Middle <i>M.</i>	Last <i>Harris</i>
4. DATE OF DEATH	Month <i>Nov</i>	Day <i>8</i>	Year <i>1959</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 20 1882</i>
9. AGE (In years last birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Harris</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Pritchard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John E Dunn</b>		Address <b>Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerosis</i> DUE TO <i>450.0</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) <i>(County)</i> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John E Dunn</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>11/8/59</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12124

12166

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b 1 mo. 9 <sup>17</sup> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. STREET ADDRESS <b>Unknown</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>T.</b>	Last <b>Edwards</b>	4. DATE OF DEATH	Month <b>11</b>	Day <b>14</b>	Year <b>19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1877</b>	9. AGE (In years lost birthday) <b>82</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Williams</b>			14. MOTHER'S MAIDEN NAME <b>Sarah</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypostatic Pneumonia</b> <b>(b)</b> DUE TO <b>Generalized Arteriosclerosis</b> <b>(c)</b> <b>Arteriosclerotic Heart Disease</b>  <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Chronic Brain Syndrome Associated with Arteriosclerosis-</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. ----- 19 -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		(County) -----	(State) -----
21. I certify that I attended the deceased from <b>9/27</b> , 19 <b>50</b> , to <b>11/14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/14</b> , 19 <b>59</b> , and that death occurred at <b>2:40P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i>				ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>11/16/59</b>			
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		Crownsville State Hospital, Md. <b>11/16/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11/25/59</b>	22b. DATE THEREOF <b>11/25/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>University Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walt Kressel Jr.</i>		ADDRESS <b>108 W. West Street</b>		24a. REC'D BY REGISTRAR <b>NOV 27 '59</b>	24b. REGISTRAR'S SIGNATURE <b>27 Nov 59</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12167

## CERTIFICATE OF DEATH

12125

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Anne Arundel. MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ft. George G. Meade.

c. LENGTH OF STAY IN TB

3 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

U.S. Army Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE

MARYLAND

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE

3 Vol. 4

d. STREET ADDRESS

1 JEFFREY ST

e. IS RESIDENCE ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

MARRIED NEVER MARRIED 

b. DATE OF BIRTH

9. AGE (In years  
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

yrs.

Months

Days

Hours

Min.

Female

Cauc.

WIDOWED DIVORCED 

12 Nov 1959.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DNA.

10b. KIND OF BUSINESS OR INDUSTRY

DNA.

11. BIRTHPLACE (State or foreign country)

USA N.- F.G.G.M.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Gordon A. FATH.

14. MOTHER'S MAIDEN NAME

Barbara A. Harmon

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

—

16. SOCIAL SECURITY NO.

INFORMANT

FATHER

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Respiratory Failure

INTERVAL BETWEEN  
ONSET AND DEATH

773.5

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

DUE TO

(b)

DUE TO

(c)

Hyaline membrane disease.

Prematurity.

30 hrs.

3 days.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 12 Nov. 1959, to 15 Nov. 1959, that I last saw the deceased alive on 15 Nov. 1959, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Wilbur W. Miller Jr.

M.D.

USA N. Ft George G. Meade. 15 Nov 59

PHYSICIAN'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)

S. River

22b. DATE THEREOF

Nov. 17, 1959

22c. NAME OF CEMETERY OR CREMATORIUM

St. Mary's Cemetery

22d. LOCATION (City, town, or county)

Hedges Town, Pa

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

George Horne 4001 Ritchie Hwy.

ADDRESS

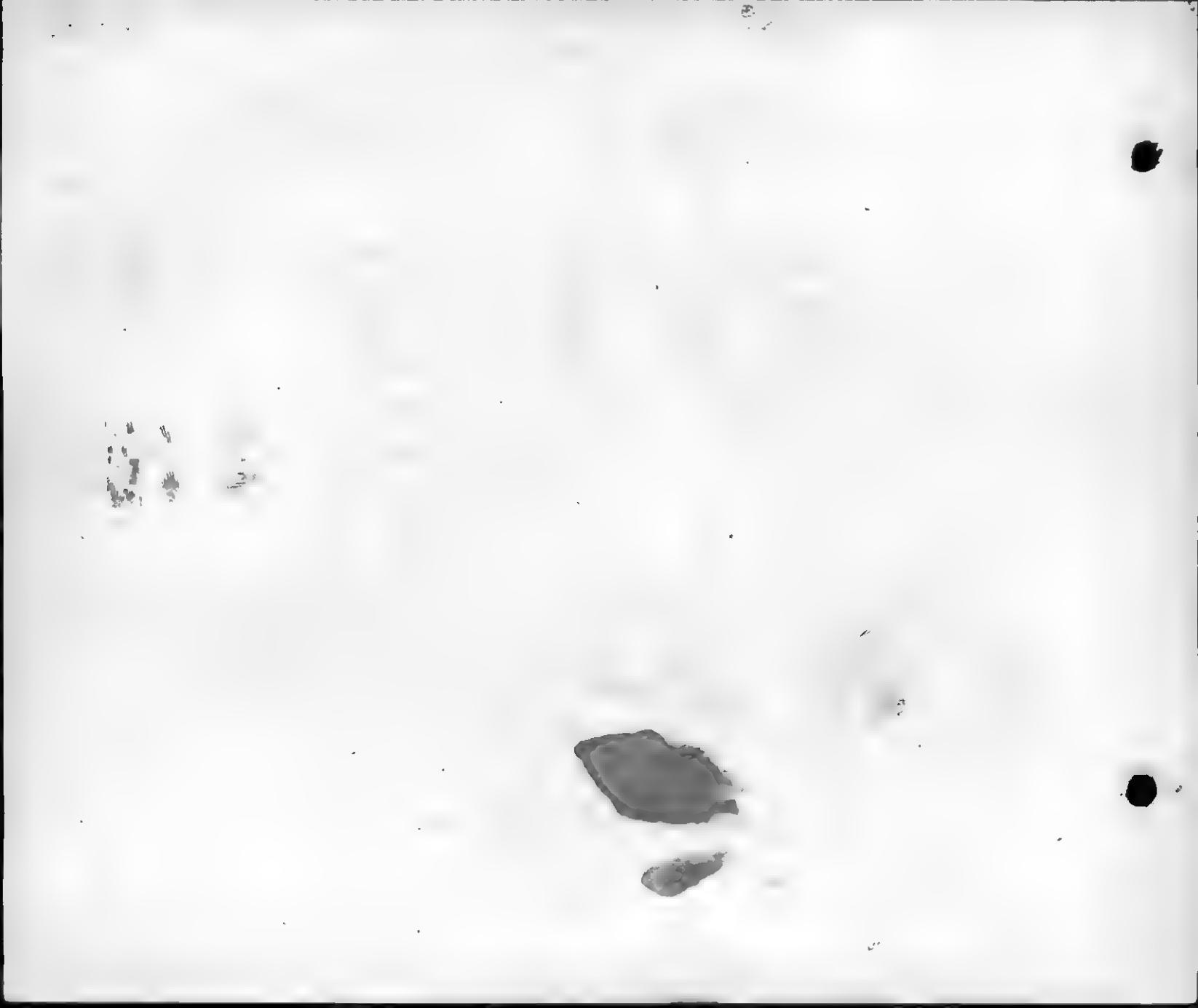
24a. REC'D BY REGISTRAR

NOV 18 '59

24b. REGISTRAR'S SIGNATURE

C. Ruth S. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



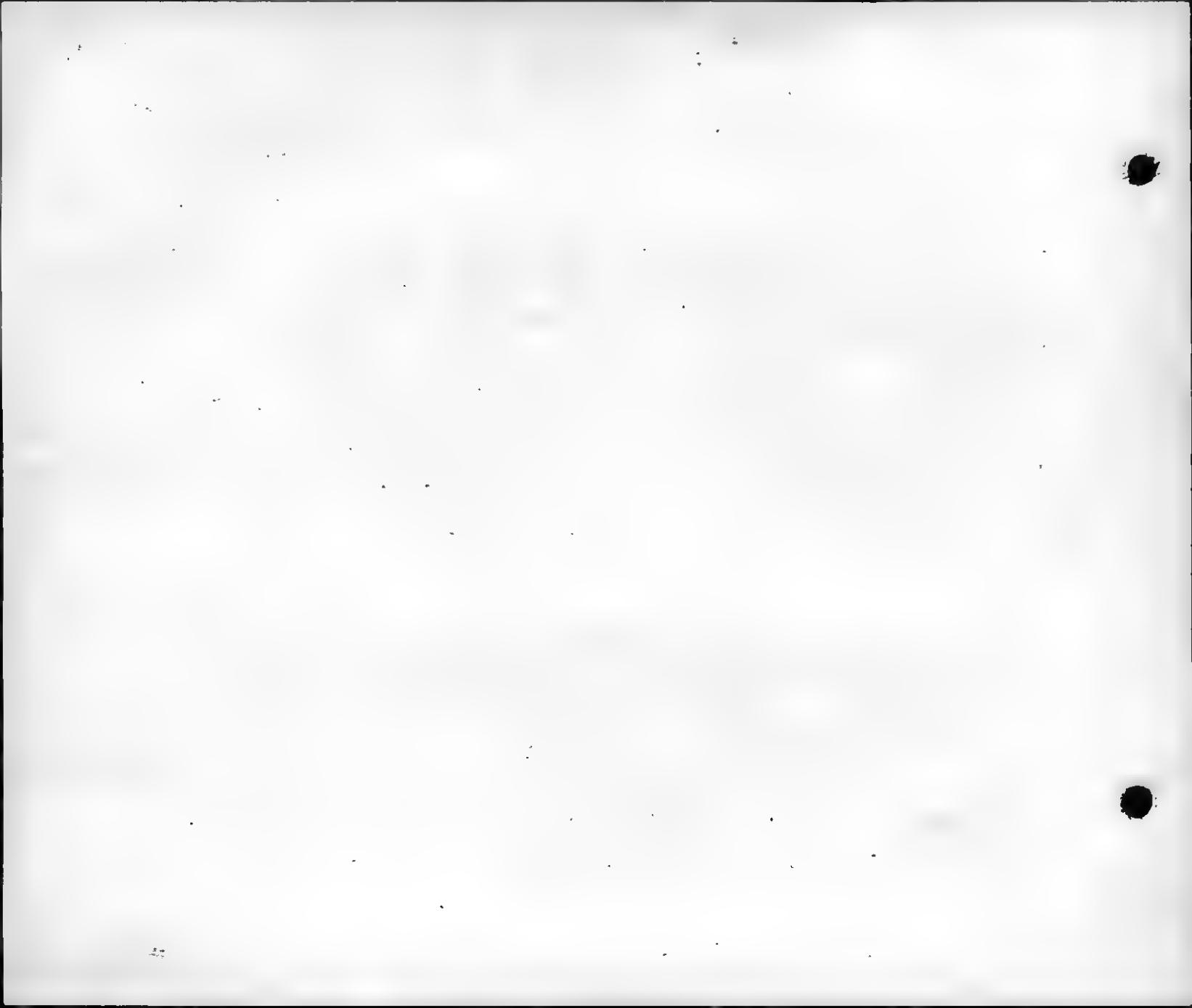
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12168 CERTIFICATE OF DEATH

12126

Reg. Dist. No.

**TO HOSPITAL OR ENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>200 Good St Rd.</i>				d. STREET ADDRESS <i>200 Good St Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Velma L. B. FEEZE</i>		First <i>V.</i>	Middle <i>E.</i>	Last <i>Feeze</i>	4. DATE OF DEATH Month <i>Nov</i> Day <i>10</i> Year <i>1959</i>
5. SEX <i>W.</i>		6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-85</i>	9. AGE (In years Just birthday) yrs. <i>74</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
13. FATHER'S NAME <i>Thomas.</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Brown.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		INFORMANT <i>Famly - Sonne</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4-10</i>		Address <i>2212 E. 26th Street</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>			
(c) DUE TO <i>hypertension</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>fell down stairs</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Baltimore, Md. Baltimore, Md. Md.</i>	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>57</i> , to <i>11-16</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11-16</i> , 19 <i>57</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3964 E. 26th Street, Baltimore, Md.</i>					
DATE SIGNED <i>11-12-57</i>					
ACTUAL SIGNATURE <i>Eugene Schaefer, M.D.</i>					
PHYSICIAN'S NAME (Type) <i>Eugene Schaefer, M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/14/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Beth Israel</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Shaefer - 130 E. Fort Lee.</i>					
ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE <i>Curtis &amp; Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

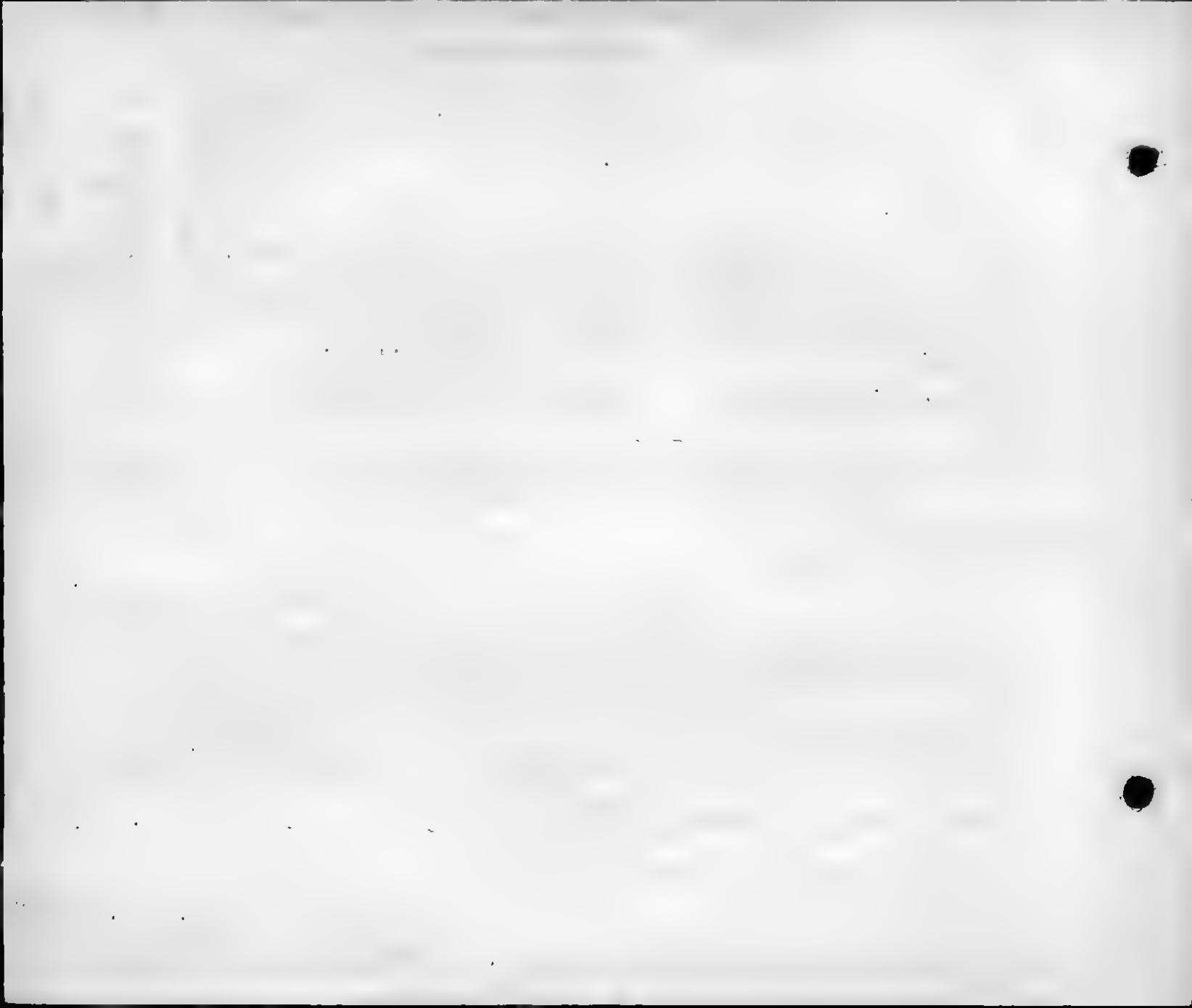
12127

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena(Rural)</b>		c. LENGTH OF STAY IN lb <b>4½ mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 299, Bar Harbor Road</b>				d. STREET ADDRESS <b>403 Joyce Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Minnie</b>	Middle	Last <b>Fuller</b>	4. DATE OF DEATH	Month <b>NOV.</b>	Day <b>2,</b>	Year <b>1959</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/1880</b>	9. AGE (In years (on birthday) <b>79</b> yrs)	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		Supply by House INDUSTRY <b>Pharmaceutical</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Warren Fuller</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-0495</b>		17. INFORMANT <b>Mrs Emma Long, Same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> INTERVAL BETWEEN DUE TO <b>2 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> SEVEN years. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 10, 1959</b> to <b>November 2, 1959</b> , that I last saw the deceased alive on <b>November 1, 1959</b> , and that death occurred at <b>5:50 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Randall M. McLaughlin, M.D. REO8 Box 442 Pasadena, Md. Nov 2, 1959</b>				DATE SIGNED			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>11/15/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore Co., Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>		ADDRESS <b>Glen Burnie, Md.</b>		24a REC'D BY REGISTRAR DATE <b>NOV 5 '59</b>		24b REGISTRAR'S SIGNATURE <b>C. M. M.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13247

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12170 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Anne Arundel Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	Md. Balt. City	
GLEN BURNIE	2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
207 CARROLL RD.	1237 LOMBARD ST BALT., MD.		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Rosaria (n) Gianforte			
4. DATE OF DEATH	Month	Day	Year
NOVEMBER 21 1959			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
F.	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12 FEB. 1885
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or Foreign country)
79 yrs.	H S W F	none	SICILY, ITALY
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Mr. Dominick Marino (dec)	Mrs. Rosaria Battaglia (dec)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	MRS. ANTONINA DUVALL-1003 OLD ANAP. BLVD. GLEN BURNIE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
ACUTE CORONARY THROMBOSIS			
INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
434.1			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last			
CONGESTIVE HEART FAILURE			
1 mo			
DUE TO			
(b)			
ADVANCED AGE			
20 yr			
C. DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
CANCER - BOTH LUNGS - 3 YRS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 20 Nov 1959 to 21 Nov 1959, that I last saw the deceased alive on 20 Nov 1959, and that death occurred at 12:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
H.F. Manuzak		EASTWAY & EDGERLY RD 21 Nov 59	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
H.F. MANUZAK		GLEN BURNIE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Nov 25-59	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
New Cathedral Cemetery		Locuston Ind	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Edmund G. Trink Gln Burnie Md		24a. REC'D BY REGISTRAR	
		DATE NOV 24 '59	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Thomas	



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

12120

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS <b>Gilliam's Corner, Defense Hwy.</b>	
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>JORDAN</b>	Last <b>GILLIAM</b>
4. DATE OF DEATH	Month <b>November</b>	Day <b>27</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1885</b>
9. AGE (In years last birthday) <b>74 yrs.</b>	10. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	11. IF UNDER 1 YEAR Months <b>0</b>	12. IF UNDER 24 HRS. Months <b>0</b>
13. FATHER'S NAME <b>William H. Gilliam</b>	14. MOTHER'S MAIDEN NAME <b>Emily Mackey</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT <b>William J. Gilliam #2</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to (c) <i>Emphysema due to esophageal obstruction by tight diaphragmatic hiatus. By gall stones</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic congestive heart failure Ac. Recklinghausen syndrome</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>As. Recklinghausen syndrome</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 26, 1959</b> , to <b>Nov. 27, 1959</b> , that I last saw the deceased alive on <b>Nov. 27, 1959</b> , and that death occurred <b>2:05 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Maurice Klawans</i>		ADDRESS (Street, city or town, state) <b>31 Southgate Ave., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>		DATE SIGNED <b>11/27/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>	22d. LOCATION (City, town, or county) <b>GLEN BURNIE</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor, Esq. Principals, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>DEC 1 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Cecilia S. Kraus</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12171

## CERTIFICATE OF DEATH

Reg. Dist. No.

12129

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) Children's Center, District Training School Laurel, Md.		STREET ADDRESS 1420 - 21st. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Donald	Middle M.	Last Greenstreet
4. DATE OF DEATH November 9 1959	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH Feb. 14, 1900	9. AGE (in years lost birthday) 59 yrs.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institution		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abber G. Greenstreet		14. MOTHER'S MAIDEN NAME Mary McKee Greenstreet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Due To Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH 12 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due To arteriosclerotic heart disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1956 to Nov 9 1959, that I last saw the deceased alive on Nov 7 1959, and that death occurred at 8 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. 11/10/59 PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. 11/10/59			
22a. BURIAL CREMATION / REMOVAL (Specify) Cremation 11/11/59		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery, Laurel, Md.	
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Donald McDonald, 313 Talbot Ave.		24b. REGISTRAR'S SIGNATURE C. Jones & Son	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

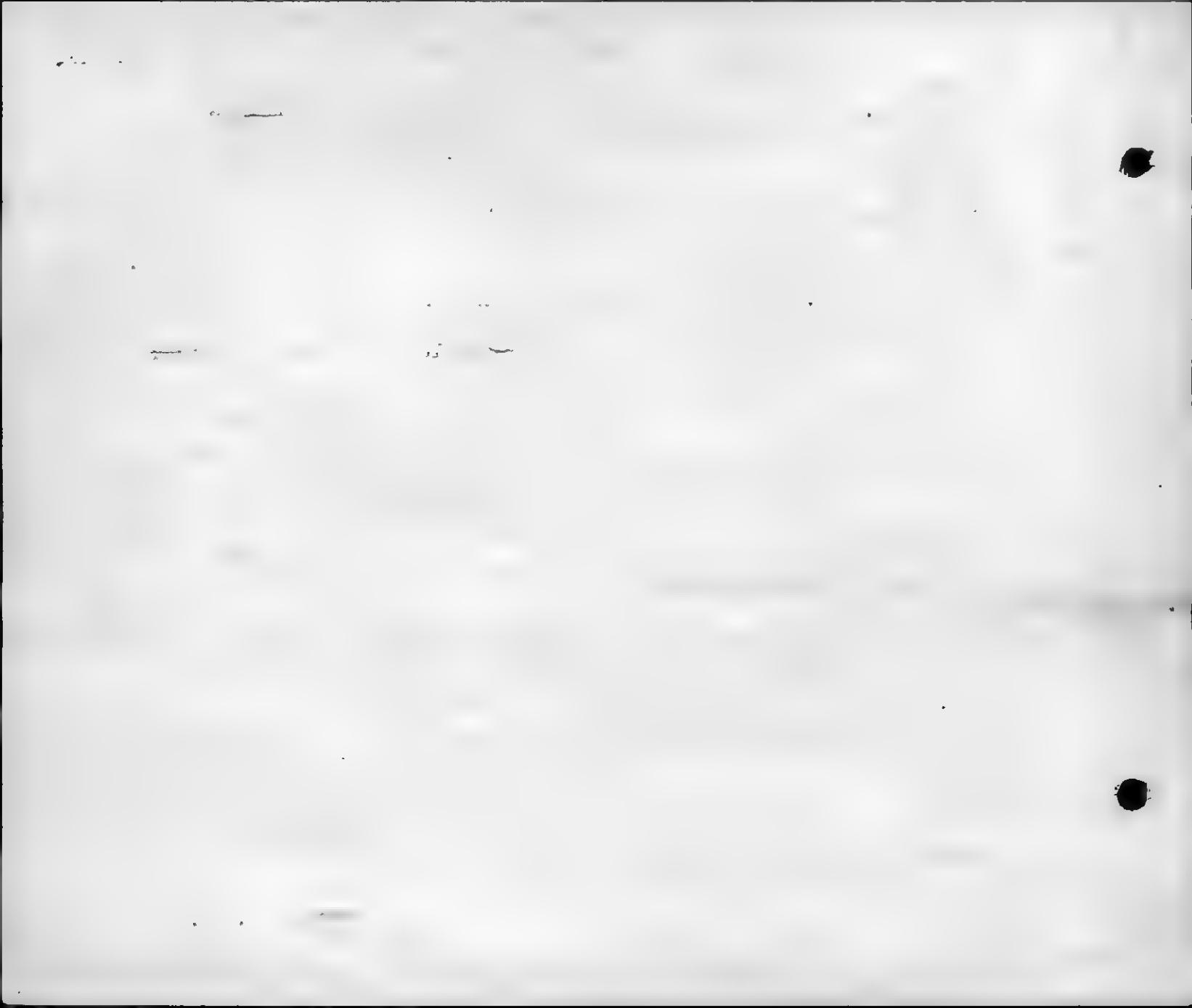
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												12130			
12172 CERTIFICATE OF DEATH												Reg. Dist. No.			
1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> <u>ANN ARUNDEL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtis Bay</u>				c. LENGTH OF STAY IN 1b <u>Life</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6815 Allenhurst Road</u>				d. STREET ADDRESS <u>6815 Allenhurst Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Joseph</u>		Middle <u>Hall</u>		Last		4. DATE OF DEATH <u>November 6th, 1959</u>		Month		Day		Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 21st-1886</u>		9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>ANN ARUNDEL</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Robert Hall</u>				14. MOTHER'S MAIDEN NAME <u>Milvina Kess</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address <u>Bertha Hall 6815 Allenhurst Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH <u>Several hrs</u>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>															
4. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Thrombophlebitis ft. leg</u> (c) <u>Cardio Vascular Disease</u>												DUE TO <u>Several days</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Oct. 10, 1959</u> to <u>Nov. 6, 1959</u> , that I last saw the deceased alive on <u>Nov. 5, 1959</u> , and that death occurred on <u>Nov. 6, 1959</u> M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <u>1607 W. Mulberry St. Baltimore 4-7-57</u>			
ACTUAL SIGNATURE <u>Richard H. Hunt</u>				DATE SIGNED <u>4-7-59</u>											
PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Mt Zion Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore Co. Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chay Wilson</u>				ADDRESS <u>100 Sonatoga</u>				24a. REG'D BY REGISTRAR <u>10/8/59</u>		24b. REGISTRAR'S SIGNATURE <u>Chay Wilson</u>				DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

12121

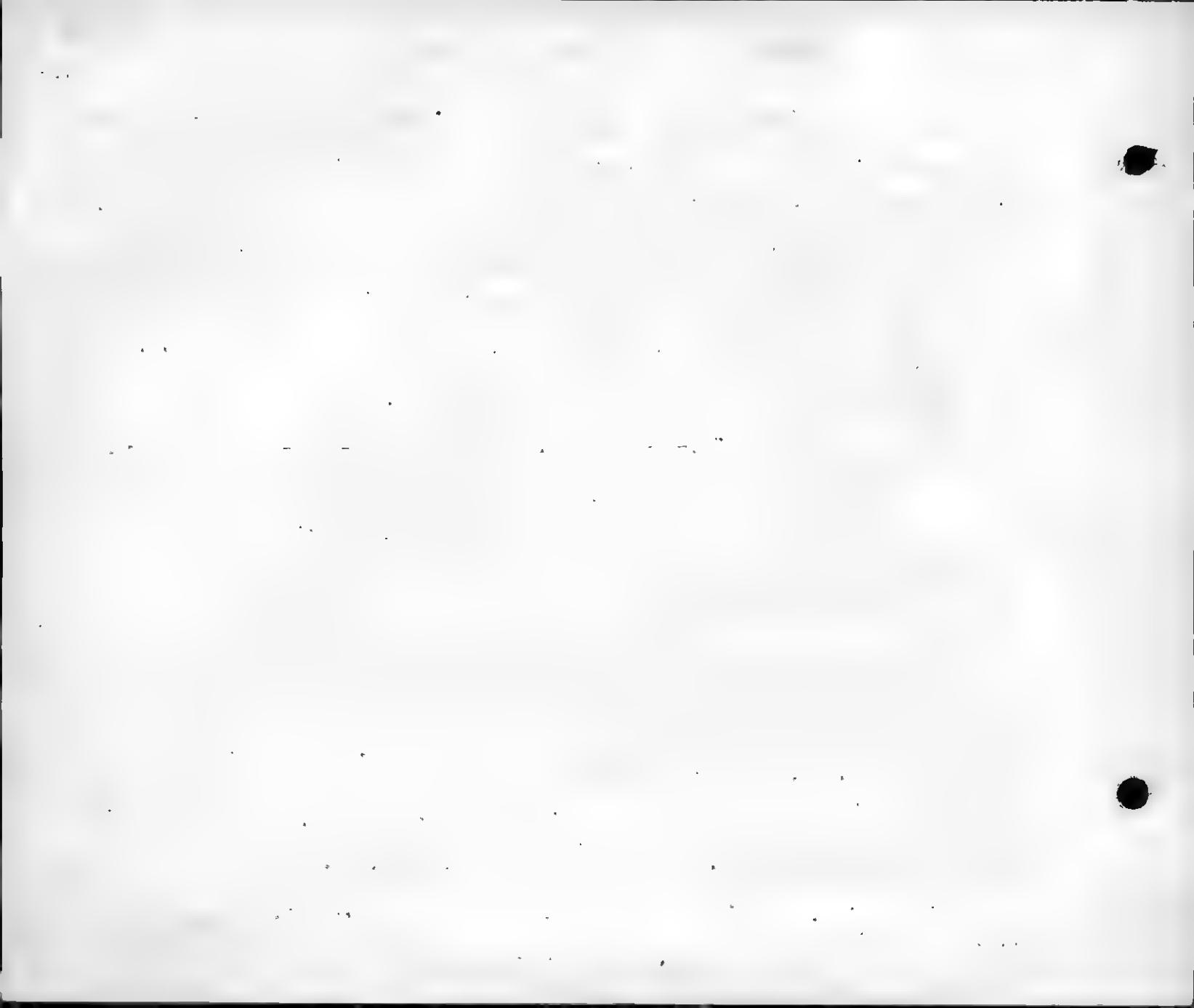
## CERTIFICATE OF DEATH

Reg. Dist. No.

Page 4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Carrie</b>	Middle <b>Mae</b>	Last <b>HARDESTY</b>	4. DATE OF DEATH	Month <b>November</b>	Day <b>11</b>	Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 1, 1889</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prop</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nemiah Brundage</b>		14. MOTHER'S MAIDEN NAME <b>Lillie C. Owens</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-34-1980</b>		INFORMANT <b>Mr. Milton Hardesty—Son—Churchton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Urinary</b> <b>Carcinoma of the bladder</b> <b>6 mo</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>98 Cathedral St.,</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 19, 1959</b> , to <b>Nov. 11, 1959</b> , that I last saw the deceased alive on <b>Nov. 10, 1959</b> , and that death occurred at <b>1:15A M</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>98 Cathedral St., Annapolis, Md.</b>							
DATE SIGNED <b>11/11/59</b>							
ACTUAL SIGNATURE <b>Edwin Davis, Jr. M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Knapp</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12173

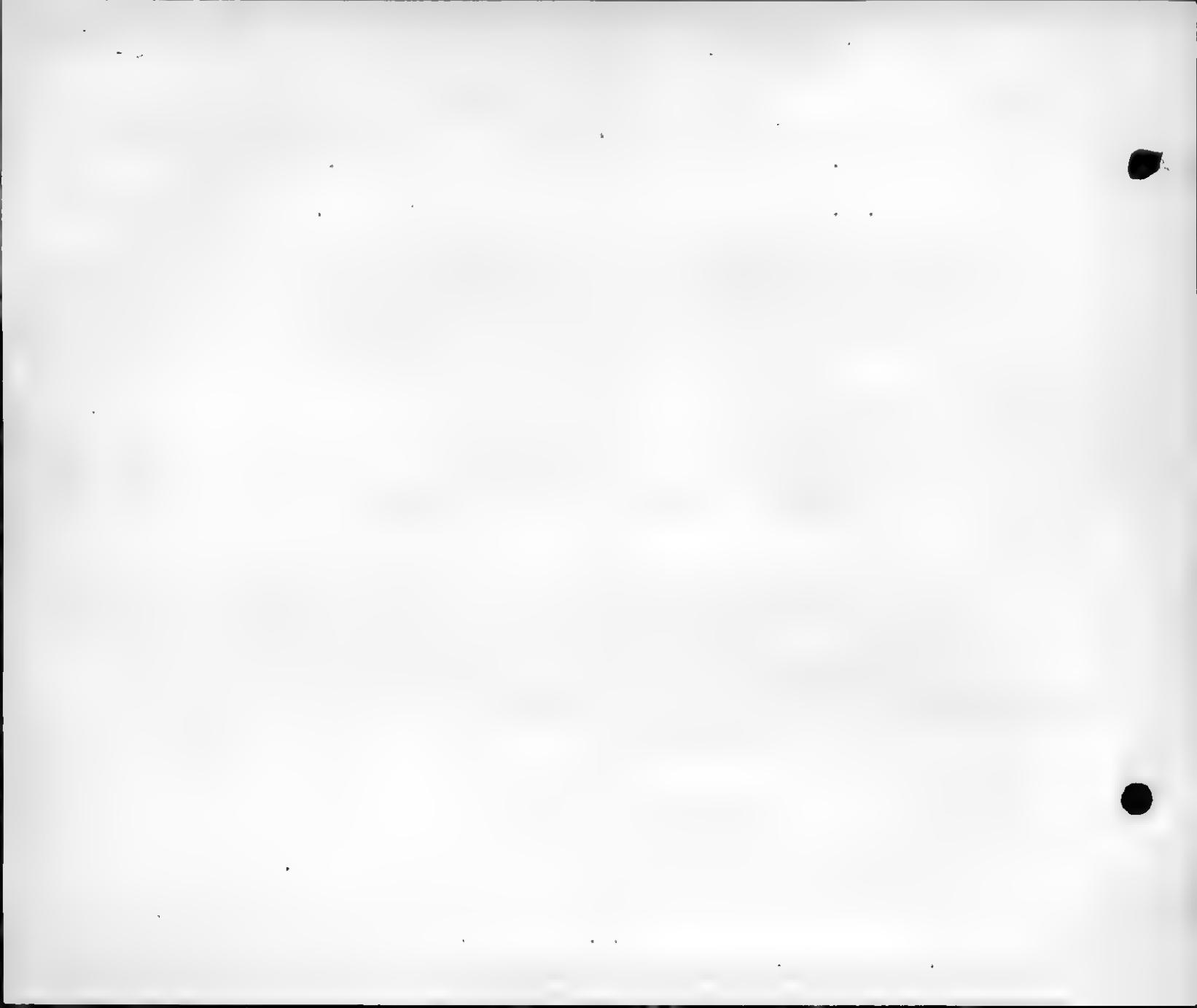
## CERTIFICATE OF DEATH

Reg. Dist. No.

12132

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Anne Arundel		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Fort George G. Meade		c. LENGTH OF STAY IN 1b  5½ hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  U. S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First  RICHARD	Middle —	Last HARPER
4. DATE OF DEATH	Month November	Day 28	Year 19 59
5. SEX  Male	6. COLOR OR RACE  Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  27 November 1959
9. AGE (In years last birthday) — yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)  Maryland
12. CITIZEN OF WHAT COUNTRY?  United States	13. FATHER'S NAME  Emanuel Harper		
14. MOTHER'S MAIDEN NAME  Evelyn Smith	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  16. SOCIAL SECURITY NO		
INFORMANT Emanuel Harper (Father)	Address 7006-C Antelak St Argonne Hills		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  116X DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5½ hours			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 27 Nov 1959, to 28 November 1959, that I last saw the deceased alive on 28 November 1959, and that death occurred at 0230 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED  ACTUAL SIGNATURE <i>Archie S. Golden</i> M.D. 28 Nov 1959			
PHYSICIAN'S NAME (Type) ARCHIE S. GOLDEN, CAPT., MC USAH, Fort George G. Meade, Maryland			
22a. BURIAL, CREMATION REMOVAL (Specify) Cremation	22b. DATE THEREOF 30 Nov 1959	22c. NAME OF CEMETERY OR CREMATORIALaboratory, U.S. Army Hospital, Fort George G. Meade, Md	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Betty H. Ellis, CAPT., MSC</i>		23d. ADDRESS U.S. Army Hosp. Fort Geo G Meade, Md	24a. REC'D BY REGISTRAR DEC 4 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN lb <i>5 yrs. 1 mo. 10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>1512 Druid Hill Avenue</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville State Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Vernon</i>	Middle <i>Louis</i>	4. DATE OF DEATH <i>March 17, 1922</i>	Month <i>11</i>	Day <i>3</i>	Year <i>1922</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>March 17, 1922</i>	9. AGE (in years last birthday) <i>37 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Harry Hunnell</i>				14. MOTHER'S MAIDEN NAME <i>Celestine Perry</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-12-3399</i>				
17. INFORMANT <i>Unknown</i>				Address <i>Hospital Records</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Paralytic Ileus</i> INTERVAL BETWEEN ONSET AND DEATH  570.5 DUE TO  Conditions, if any, which gave rise to immediate cause (b) <i>Intestinal Obstruction</i>  (a), stating the underlying cause lost. DUE TO  (c) <i>Old Post-Operative Adhesions</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM ILLDISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Maryland</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>E. L. Bratt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11/4/59</i>		
EXAMINER'S NAME (Type) <i>E. L. Bratt</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/8/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles C. Bratt</i>		ADDRESS <i>1610 W. 34th Street</i>		24a. REC'D BY REGISTRAR <i>REC'D 6-19-59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		
				DATE <i>11/4/59</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

BURIAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



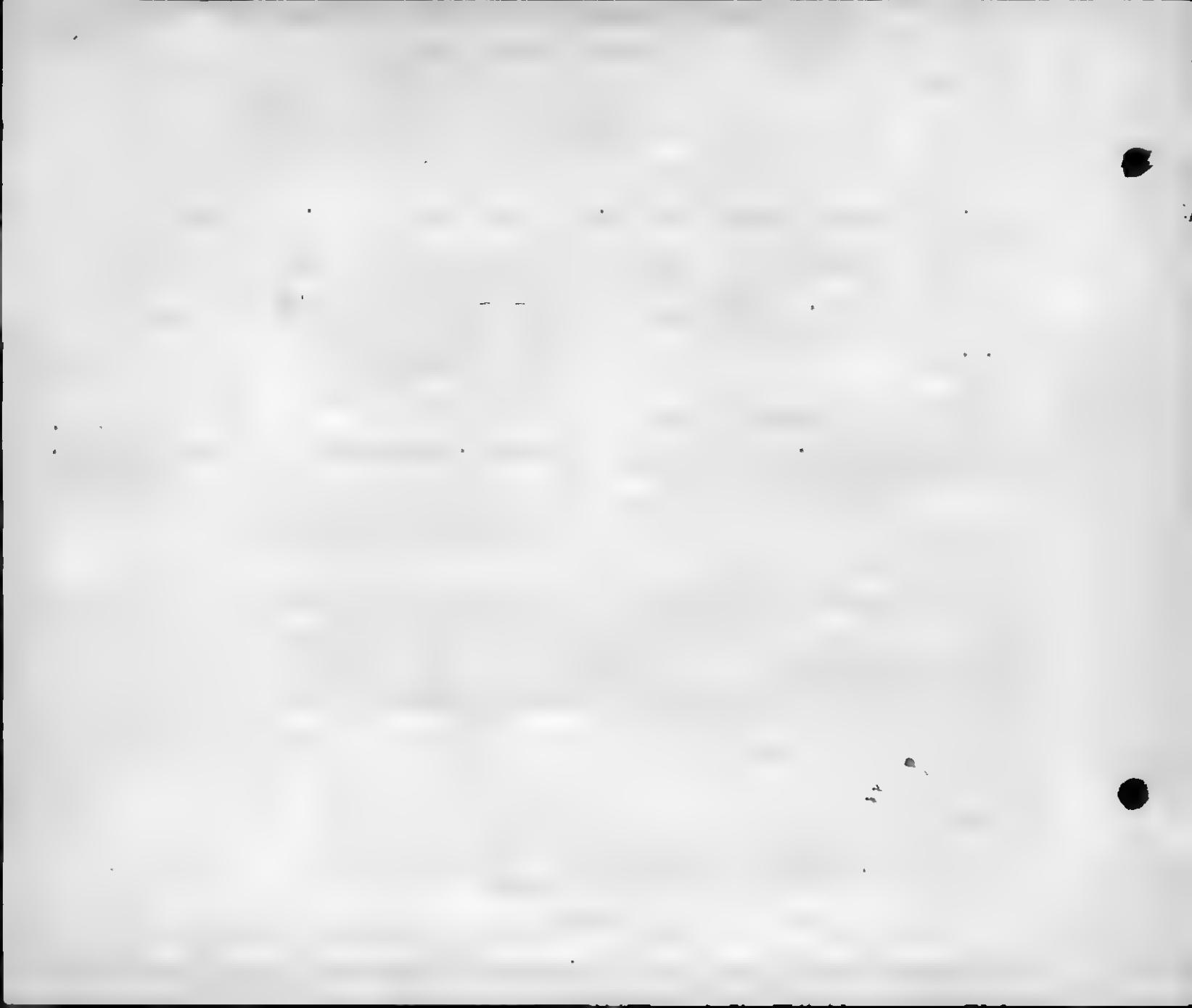
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 10 Film 252 11-26-59 ams 12122

12134

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.	
d. STREET ADDRESS 75 PRINCE GEORGE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Jerome	Last JACOBSON
4. DATE OF DEATH	Month 11	Day 10	Year 19 59
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-86
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JACOBSON, Jacob		14. MOTHER'S MAIDEN NAME GANNON, Margaret	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES 20 Yrs.		16. SOCIAL SECURITY NO. 17. INFORMANT Address Annapolis, Md. Lillian D. JACOBSON (W) 75 Prince George St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Chronic Pulmonary Emphysema 20+ 4 1/2 yrs XX X X X X X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chronic bronchitis 20+ 20+			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1951, to Nov 10, 1951, that I last saw the deceased alive on Nov 10, 1951, and that death occurred at 4:40 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. BUSCH LT MC USNR		ADDRESS (Street, city or town, state) VSNAH - Annapolis Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) S. BUSCH LT MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-59	
22c. NAME OF CEMETERY OR CREMATORIAL National		22d. LOCATION (City, town, or county) Annapolis Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE NOV 16 1951	
		24b. REGISTRAR'S SIGNATURE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12175

Items 8,9 fill in 1-12-10 et

Reg. Dist. No.

13262

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
Baltimore County MARYLAND		a. STATE	b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Crownsville	124PS	1251 DRUID HILL Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Crownsville State Hosp	Baltimore MD				
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
	Leon		SAMISON		
4. DATE OF DEATH	Month	Day	Year		
	11	3	1959		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		
Male	Negro		1925??		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Crownsville	---	New Jersey	—		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
Samuel Samison	Ironside				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
Unknown		Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 795.0 DUE TO Peripheral Circulatory Fr. Due to					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exposure to cold and Starvation DUE TO					
(c)					
INTERVAL BETWEEN ONSET AND DEATH 1-2 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>E. L. Lohr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12/17/59</i>	
EXAMINER'S NAME (Type) <i>E. L. Lohr</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Crownsville State Hosp.	22d. LOCATION (City, town, or county) (State) Crownsville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward J. Lohr, Esq.</i>		ADDRESS Crownsville State Hospital	24a. REC'D BY REGISTRAR DATE DEC 28 '59	24b. REGISTRAR'S SIGNATURE <i>Calvin S. Thorne</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12123

## CERTIFICATE OF DEATH

12135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>HARVEY PRUNDEL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIVIA</i>		c. LENGTH OF STAY IN 1b <i>11-10-59</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <i>R.H. GENERAL Hospital</i>		e. STREET ADDRESS <i>RIVA RD RT #1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.H. GENERAL Hospital</i>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Annie May Johnson</i>		Last <i>Johnson</i>	4. DATE OF DEATH Month <i>11</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-20-1910</i>
9. AGE (In years last birthday) <i>49 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>NORTH CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Roy Hewitt</i>		14. MOTHER'S MAIDEN NAME <i>"UCK"</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Roy L. Johnson</i>		Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Anticoagulant CVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
(b) DUE TO <i>—</i>			
(c) DUE TO <i>—</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>Staphylococcal infection</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.) <i>—</i>	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>1956</i> to <i>11-7-1958</i> , that I last saw the deceased alive on <i>11-6-1958</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>I. Paul Marshall</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>Frank Marshall</i> DATE SIGNED <i>11-8-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-10-59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>HILLCREST</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Yost &amp; Sons Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 12 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Edwin S. Trahan</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12136

**12124**

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>69 Clay St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Debra</b>	Middle <b>Ann</b>	Last <b>JOHNSON</b>	4. DATE OF DEATH	Month <b>November</b>	Day <b>24</b>	Year <b>19 59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 8, 1959</b>	9. AGE (In years last birthday) <b>2 mos.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>16</b> Hours <b>5</b> Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <i>Jack Sylvester Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Stevens</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>525X</b>		INFORMANT <i> Father survived (Bilateral) Theron M. </i>	Address <i> Theresa Stevens 69 Clay st</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>21. I certify that I attended the deceased from 11/24/59, 1959, to 11/25/59, 1959, that I last saw the deceased alive on 11/24/59, 1959, and that death occurred at 10:10 P.M. from the causes and on the date stated above.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>110 Clay St.</b>	20f. (City or town) <b>Annapolis</b>	(County) <b>Md.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from 11/24/59, 1959, to 11/25/59, 1959, that I last saw the deceased alive on 11/24/59, 1959, and that death occurred at 10:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. L. Richardson</i>				ADDRESS (Street, city or town, state) <b>110 Clay St., Annapolis, Md.</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial 11-28-1959</b>		22b. DATE THEREOF <b>11-28-1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Reservoir Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Katherine J. Richardson</i>		ADDRESS <b>110 Clay St., Annapolis, Md.</b>	24a. REC'D BY REGISTRAR <b>NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Calvin S. Thomas</i>		



12137

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12125 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>ALEXANDRIA</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGHENY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE HOSPITAL, BALTIMORE, MD.</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BETHESDA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE HOSPITAL, BALTIMORE, MD.</b>				d. STREET ADDRESS <b>103 EBT RD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Donald</b>	Middle <b>E.</b>	Last <b>JOHNSON</b>	4. DATE OF DEATH	Month <b>11</b>	Day <b>10</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3 July 1959</b>	9. AGE (In years last birthday) <b>4 yrs.</b>	IF UNDER 1 YEAR <b>Months 4</b>	IF UNDER 24 HRS. <b>Days 7</b>	Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>US</b> , <b>ALLEGHENY, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Donald G. JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>Betty J. HANNA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>GLEN BURNIE, MD 21230</b>	
(If yes, give war or dates of service)				(F) <b>Donald G. JOHNSON 103 Beth Rd., Glen Burnie</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>'546</b> DUE TO <b>HEART FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>COARTATION OF AORTA</b> 4 mo. 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>a.m.</b> p. m. <b>p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E.L. W. HANNA</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>11/10/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>11/10/59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>ALLEGHENY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ALLEGHENY CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Glavin</i>				ADDRESS <b>4500 BROADWAY</b>			
ATTN: K. H. GLAVIN, GLEN BURNIE, MARYLAND				24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>			
				24b. REGISTRAR'S SIGNATURE <i>John H. Glavin</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12138

12126

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	c. LENGTH OF STAY IN 1b <b>16 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Lothian</b>	d. STREET ADDRESS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Lonnie</b>	Middle <b>Jesse</b>	Last <b>JOHNSON</b>	4. DATE OF DEATH <b>November 5, 1959</b>	Month <b>November</b>	Day <b>21</b>	Year <b>1959</b>
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S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>November 5, 1959</b>	9. AGE (In years last birthday) yrs. <b>16</b>	IF UNDER 1 YEAR Months <b>16</b>	IF UNDER 24 HRS. Days <b>7</b>	Hours <b>35</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13. FATHER'S NAME <b>Benjamin Roosevelt JOHNSON</b>	14. MOTHER'S MAIDEN NAME <b>Gertrude Beatherlia SELLMAN</b>	INFORMANT <b>Hospital Records</b>	Address
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18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laryngopharyngitis , E. Coli organism</b>		<b>2 wks.</b>
474X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		
DUE TO		

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>malnutrition and dehydration</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nov. 20</b>
20f. (City or town) <b>River Club Estates</b>	(County)	(State)	

21. I certify that I attended the deceased from <b>Nov. 20, 1959</b> , to <b>Nov. 21, 1959</b> , that I last saw the deceased alive on <b>Nov. 21, 1959</b> , and that death occurred <b>11:55 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Edgewater, Md.</b>	DATE SIGNED <b>11/23/59</b>
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ACTUAL SIGNATURE <i>James I. Hudson, Jr.</i>	M.D.
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PHYSICIAN'S NAME (Type) <b>James I. Hudson, Jr.</b>	Edgewater, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-24-1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Edgewater Cemetery</b>	22d. LOCATION (City, town, or county) <b>Edgewater, Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>William R. Bennett / 108 Maryland Avenue</i>	ADDRESS <b>Clifton Park, N.Y.</b>	24a. REC'D BY REGISTRAR DATE <b>NOV 25 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>
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**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12176

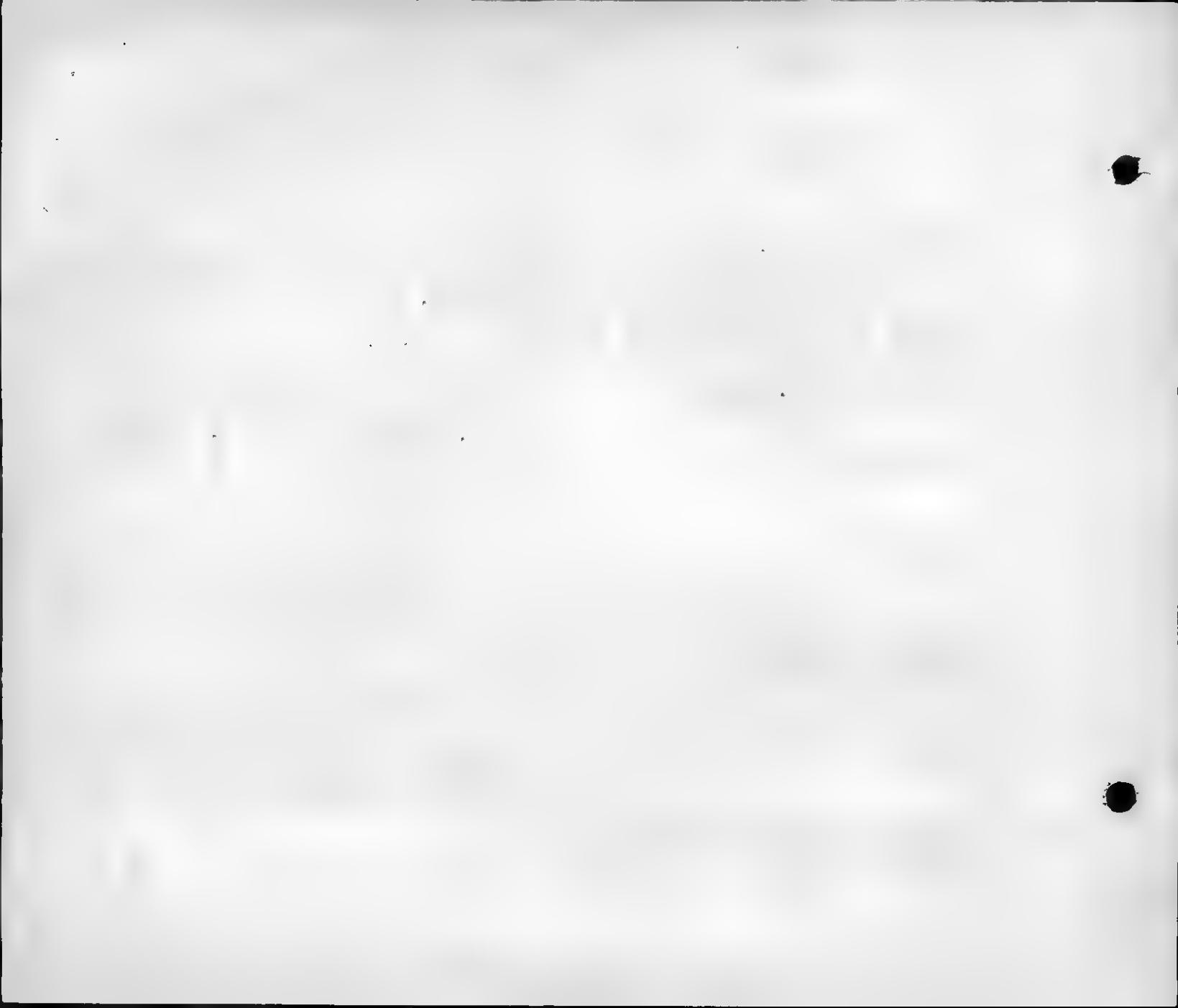
## CERTIFICATE OF DEATH

Reg. Dist. No.

12139

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b>		c. LENGTH OF STAY IN 1b <b>5 YRS</b>	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>HARFORD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CROWNSVILLE STATE HOSP</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b>		d. STREET ADDRESS <b>DORSEY AVE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	WILLIAM	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH <b>March 15, 1879</b>	9. AGE (In years last birthday) <b>80 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William F. Kenly</b>		14. MOTHER'S MAIDEN NAME <b>Tina Peaco</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>123-45-6789</b>		17. INFORMANT <b>Isiah H. Kenly</b>	Address <b>Box 147 Perryman, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), causing (c), stating the underlying cause lost. <b>SENIILITY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Crowns</b>		20f. (City or town) <b>Aberdeen</b>	(County) <b>Maryland</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>Nov 25, 1959</b> , to <b>Dec 2, 1959</b> , that I last saw the deceased alive on <b>Nov 25, 1959</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Aberdeen, Maryland</b> DATE SIGNED <b>11/27/59</b>								
ACTUAL SIGNATURE <b>Carol A. Schlegel</b>		PHYSICIAN'S NAME (Type) <b>M.D. CROWNS</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/1/1959</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Union Methodist</b>		22d. LOCATION (City, town, or county) <b>Aberdeen Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Barron - Aberdeen M.D.</b>		ADDRESS <b>John G. Barron - Aberdeen M.D.</b>		24a. REC'D BY REGISTRAR DATE DEC 4 '59	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

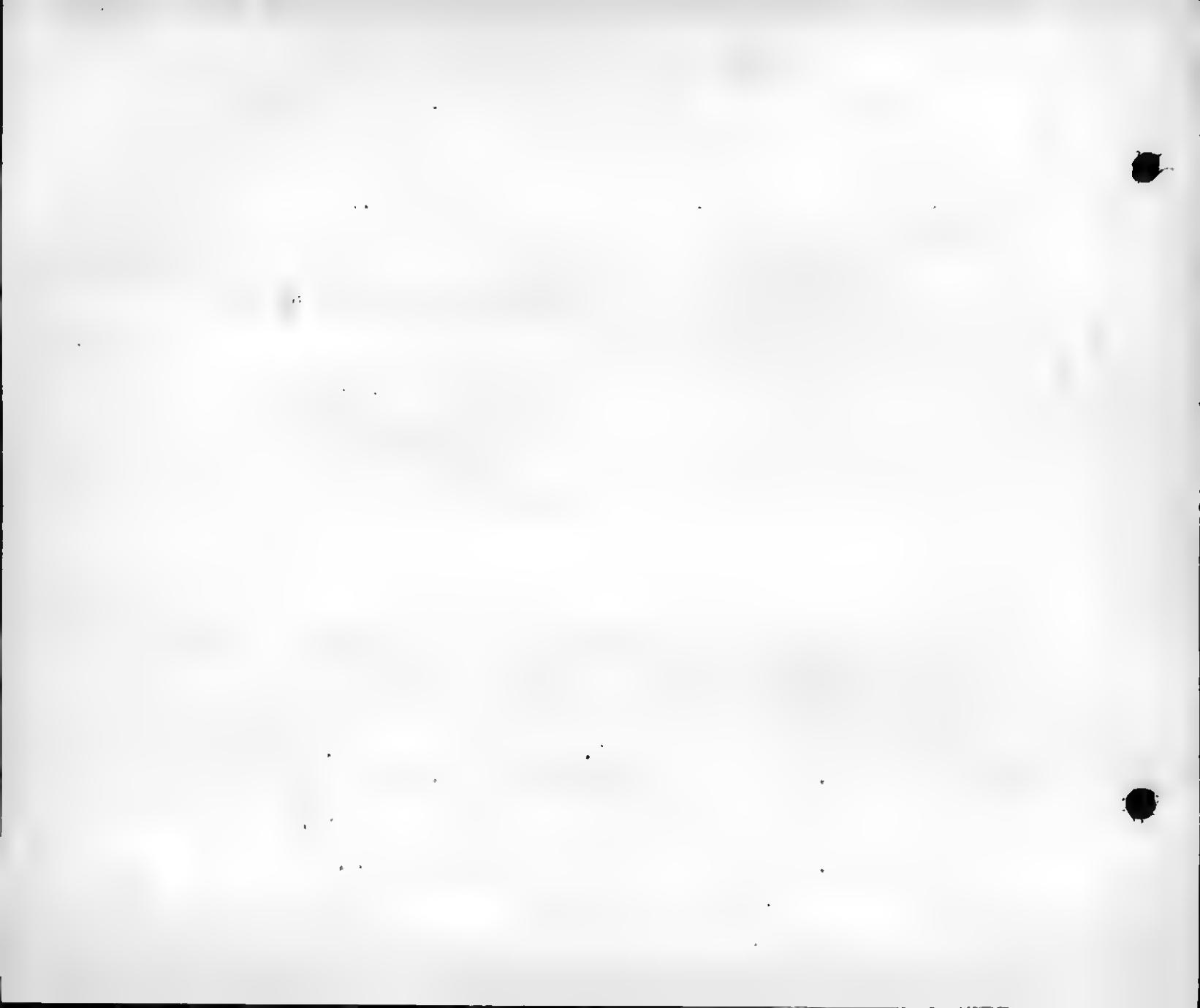
12140

12127

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Annapolis	c. LENGTH OF STAY IN 1b  RURAL and give nearest town)	b. COUNTY  Anne Arundel	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Annapolis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Anne Arundel General Hospital	e. STREET ADDRESS  1 63 West St.,	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  Kyriakos	First  Kyriakos	Middle  KOUSERTARY	Last  KOUSERTARY
4. DATE OF DEATH  November 15, 1959	Month  November	Day  15	Year  1959
5. SEX  Male	6. COLOR OR RACE  White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  November 22, 1901
9. AGE (In years last birthday) yrs.  58	10. KIND OF BUSINESS OR INDUSTRY  Lunch Room	11. BIRTHPLACE (State or foreign country)  Greece	12. CITIZEN OF WHAT COUNTRY?  GREECE
13. FATHER'S NAME  "Jack"	14. MOTHER'S MAIDEN NAME  "Jack"	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  No	
16. SOCIAL SECURITY NO.  151X	INFORMANT  Hospital records	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 8 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from Oct. 13, 1959, to Nov. 15, 1959, that I last saw the deceased alive on Nov. 15, 1959, and that death occurred at 10:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John L. Hedeman</i>		ADDRESS (Street, city or town, state) M.D. 121 Cathedral St., Annapolis, Md.	
DATE SIGNED 11/16/59			
PHYSICIAN'S NAME (Type) John L. Hedeman		22d. LOCATION (City, town, or county) Annapolis Md.	
22e. BURIAL, CREMATION: REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-17-59	22c. NAME OF CEMETERY OR CREMATORY St. JAMES
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Hedeman</i>		ADDRESS Annapolis, Md.	24a. REC'D BY REGISTRAR DATE NOV 20 '59
			24b. REGISTRAR'S SIGNATURE P. L. & Co. Inc.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

## CERTIFICATE OF DEATH

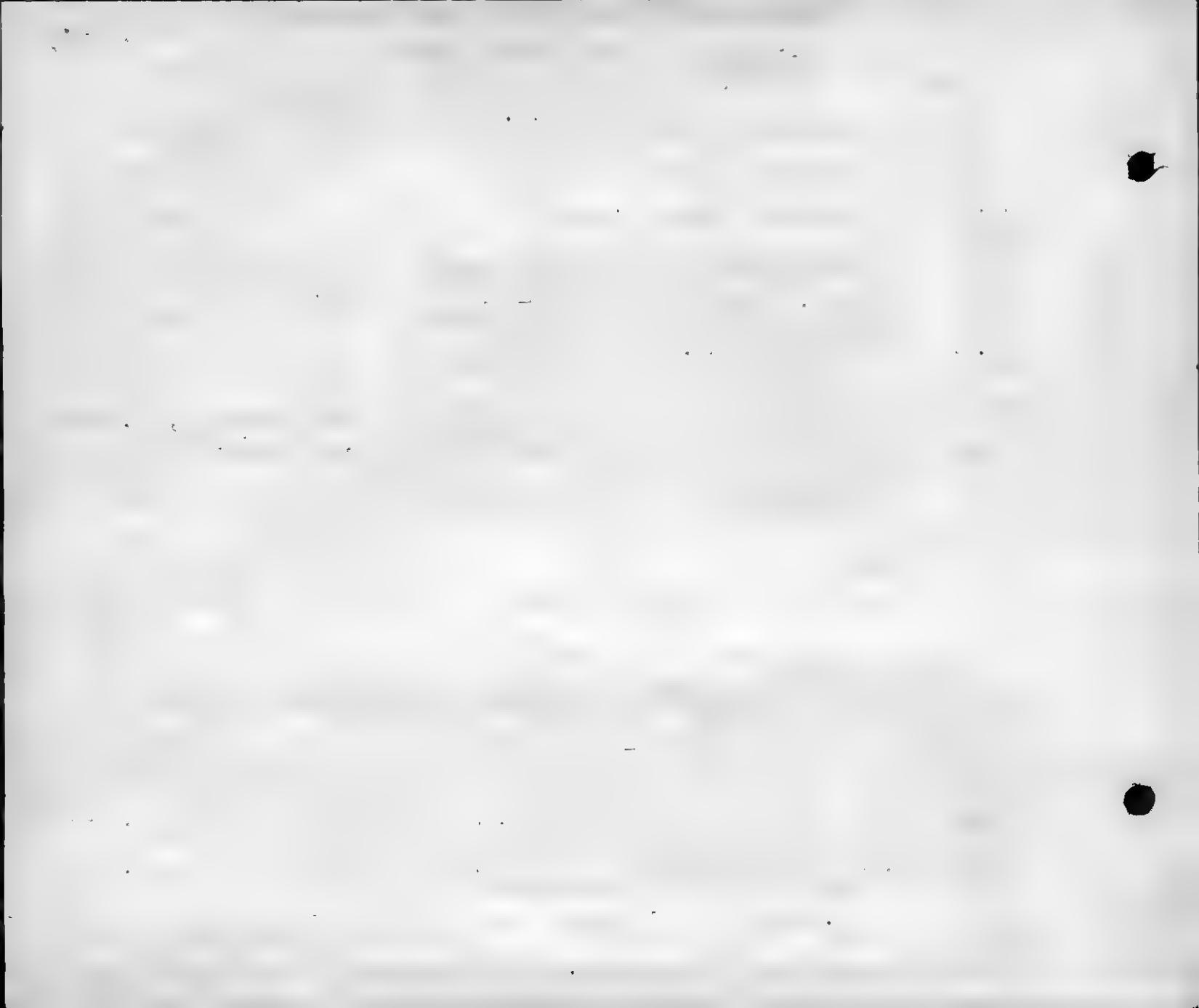
Reg. Dist. No.

12141

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD. ANNE ARUNDEL</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X A NAPOLIS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>		e. STREET ADDRESS <b>RD2 BOX 116 ST. MARGARET ST.,</b>		f. DATE OF DEATH <b>NOVEMBER 1</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD HARRISON LITTLE</b>		First	Middle	Last	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>6-27-89</b>	9. AGE (in years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. NAVY</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>	11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>				
13. FATHER'S NAME <b>HARRY LITTLE</b>		14. MOTHER'S MAIDEN NAME <b>MARIE BLOODGOOD</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WNL &amp; 11 220-07-8601A</b>		17. INFORMANT <b>Lillian Little RD2 Annex 116, St. Margaret ST., Annapolis, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>190.7</b> DUE TO Melanoma Malignant		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO  (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-30</b> , 19 <b>59</b> to <b>11-1</b> , 19 <b>59</b> that I last saw the deceased alive on <b>31 October</b> , 19 <b>59</b> , and that death occurred at <b>0440A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.C. Laning</i>		ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. 11-2-59</b>					
PHYSICIAN'S NAME (Type) <b>R.C. LANING LCDR MC USN</b>		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 3, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Naval Academy Cemet.</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 4 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12129

## CERTIFICATE OF DEATH

12142

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneapolis</i>	c LENGTH OF STAY IN lb	b. COUNTY <i>Anne Arundel</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anneapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>120 Granada Ave.</i>	d STREET ADDRESS <i>120 Granada</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary Scala Lorez</i>	First	Middle	Last			
4. DATE OF DEATH <i>November 12 1959</i>	Month	Day	Year			
5. SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7. DATE OF BIRTH <i>July 19 1888</i>	8. AGE (In years last birthday) <i>71 yrs.</i>	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home.</i>	11. BIRTHPLACE (State or foreign country), <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Louis Scala</i>	14. MOTHER'S MAIDEN NAME <i>Mary Anna Annanatta</i>		Address <i>Mrs Anna Taylor #2</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>111-11-1111</i>	17. INFORMANT <i>Mrs Anna Taylor</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>11 Southgate Ave.</i>	20f. (City or town) <i>Anneapolis</i>	(County) <i>Md.</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>May 1, 1954</i> , to <i>Nov 18, 1959</i> , that I last saw the deceased alive on <i>Nov 18, 1959</i> , and that death occurred at <i>11 Southgate Ave., Minneapolis, Md.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Edward J. Beck</i>	ADDRESS <i>11 Southgate Ave., Minneapolis, Md.</i>	DATE SIGNED <i>11/20/59</i>				
PHYSICIAN'S NAME (Type) <i>John W. Taylor &amp; Sons</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-21-1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's</i>	22d. LOCATION (City, town, or county) <i>Anneapolis</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor &amp; Sons</i>	ADDRESS <i>Anneapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12177

## CERTIFICATE OF DEATH

Reg. Dist. No.

12143

1. PLACE OF DEATH o COUNTY  AA		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE MD b. COUNTY BN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Glen Burnie	c. LENGTH OF STAY IN TB  yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  X Stone Harbor					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Paul Drive - Bay 303	d. STREET ADDRESS  Paul Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First  Edna	Middle  V.	Last  Lyett	4. DATE OF DEATH  Aug 15, 1886	Month 11 - Day 19 - Year 1947		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  Aug 15, 1886	9. AGE (In years, last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife		10b. KIND OF BUSINESS OR INDUSTRY  —	10c. BIRTHPLACE (State or foreign country)  MD.	12. CITIZEN OF WHAT COUNTRY?  USA			
13. FATHER'S NAME  Thomas Burke	14. MOTHER'S MAIDEN NAME  Eliza. Sabley				Address  Same		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO	16. SOCIAL SECURITY NO  —	INFORMANT  Family					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO  Carcinoma of the stomach INTERVAL BETWEEN ONSET AND DEATH 6 months							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO  (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <u>September 15, 1953</u> , to <u>November 19, 1959</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 1959, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) R. M. McLaughlin M.D. 808 Boylston Pasadena, Md. Nov. 19, 1959 DATE SIGNED						ACTUAL SIGNATURE	
PHYSICIAN'S NAME (Type)	R. M. McLaughlin						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-59	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park	22d. LOCATION (City, town, or county) Baltimore, Md.			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HCC-114 Funeral Home	ADDRESS 120 E. Loudon	24a. REC'D BY REGISTRAR DATE NOV 23 '59				24b. REGISTRAR'S SIGNATURE Charles J. Trahan	

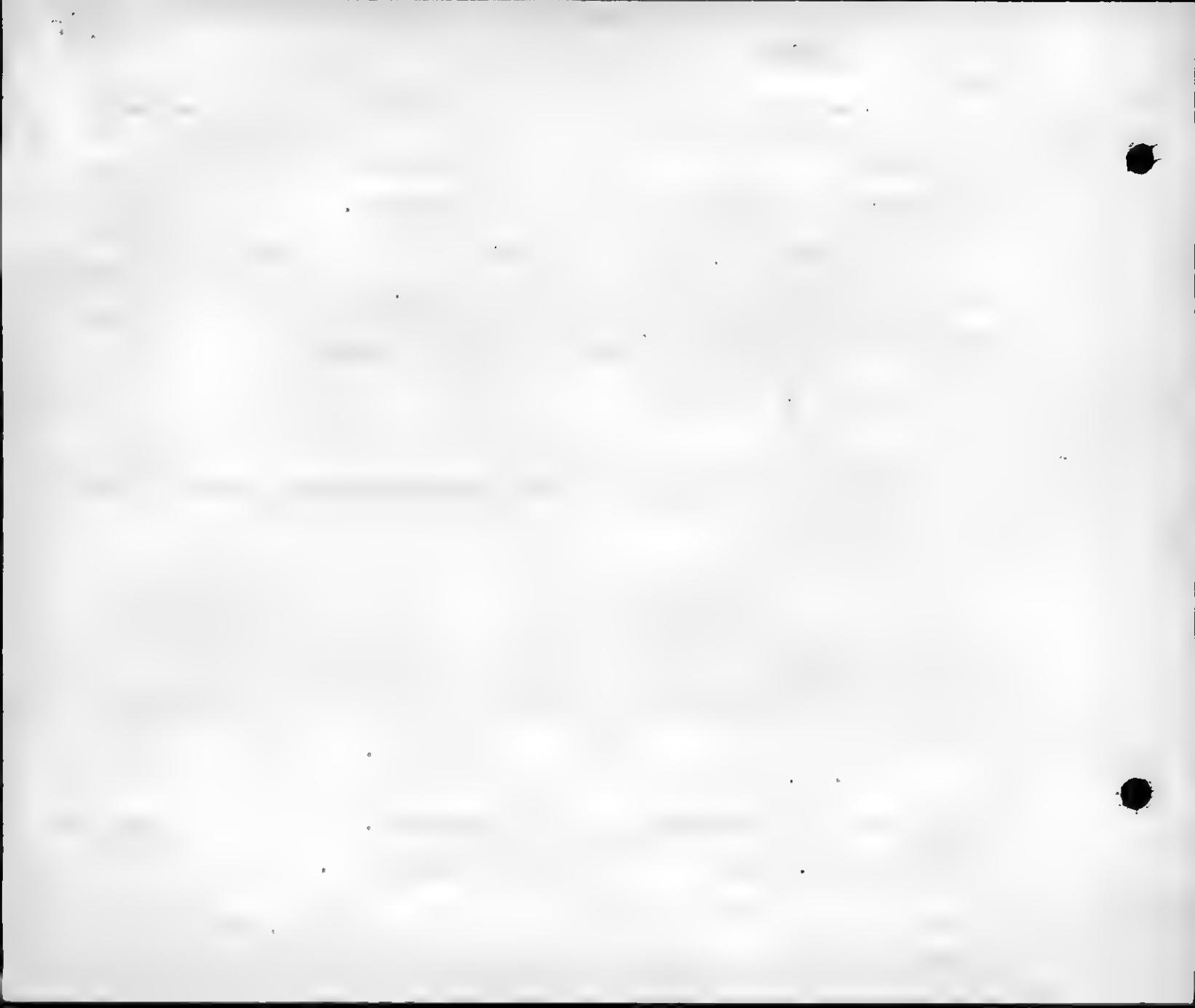


1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please sign and completely fill in by the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>										12144		
<b>12130 CERTIFICATE OF DEATH</b>										Reg. Dist. No.		
<b>1. PLACE OF DEATH</b> o. COUNTY Anne Arundel MARYLAND					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			d. STREET ADDRESS 125 Market St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital												
<b>3. NAME OF DECEASED</b> (Type or print) Roberta		First	Middle	Last	<b>4. DATE OF DEATH</b> November 26 1959		Month	Day	Year			
<b>5. SEX</b> Female		6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> January 3, 1906		9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Reg. Nurse		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Reg Nurse		<b>11. BIRTHPLACE</b> (State or foreign country) TANEYTOWN MD		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A						
<b>13. FATHER'S NAME</b> CHARLES A ELLIOT				<b>14. MOTHER'S MAIDEN NAME</b> Unknown								
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> Yes, no, or unknown		<b>16. SOCIAL SECURITY NO.</b>		<b>INFORMANT</b> MARY Jo LINDSAY (2)		Address						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO lying cause lost. (c)										Malignant neoplasm of unspecified site (199) 7 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1B)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County)		(State)		
<b>21. I certify that I attended the deceased from</b> March 1959, to Nov. 26, 1959, that I last saw the deceased alive on Nov. 26, 1959, and that death occurred at 1:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 6 Shaw St., 11/27/59										
<b>ACTUAL SIGNATURE</b> 												
<b>PHYSICIAN'S NAME (Type)</b> James R. Martin		Annapolis, Md.										
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>22b. DATE THEREOF</b> Nov 30-59		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> St. Mary's Cemetery		<b>22d. LOCATION (City, town, or county)</b> Annapolis		(State) Md.				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> 		<b>ADDRESS</b> Annapolis Md		<b>24a. REC'D BY REGISTRAR</b> DEC 1 '59		<b>24b. REGISTRAR'S SIGNATURE</b> 						
VS A15 (4) 15M 9/58												



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12145

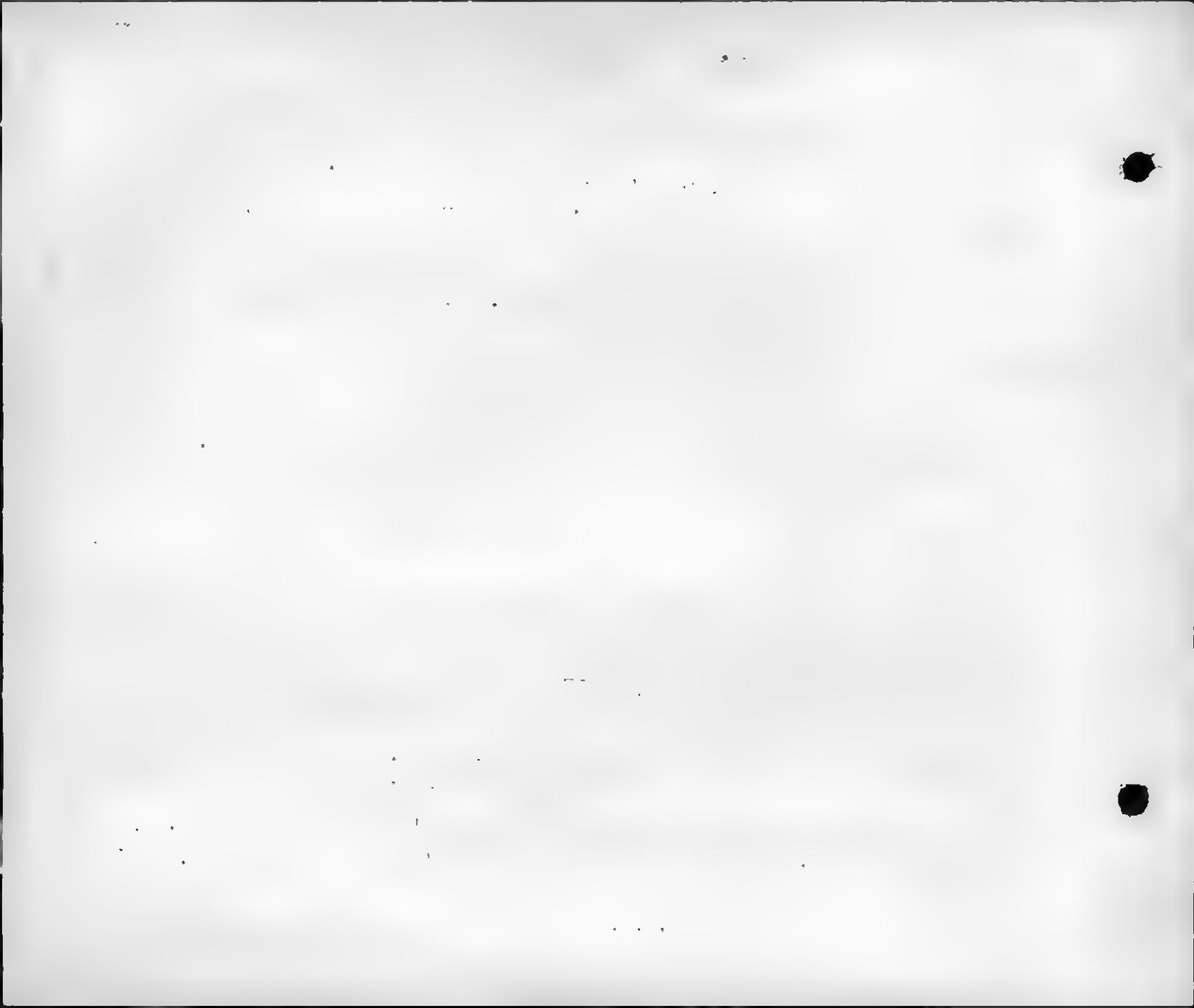
12178

## CERTIFICATE OF DEATH

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland		c. LENGTH OF STAY IN lb 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School, Laurel, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 41x. 2	
f. STREET ADDRESS 1404 - 22nd Street S.E.		g. IS RESIDENCE ON A FARM? Y YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF  (Type or print) First LOIS Middle MAE Last MANN		4. DATE DEATH Month November Day 22, Year 1959	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1925	
9. AGE (In years last birthday) 34 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institution		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isham Wesley Mann		14. MOTHER'S MAIDEN NAME Torpley Mann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Address Children's Center, Laurel, Md.	
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Cardiovascular collapse status epilepticus 2 hrs. convulsive disorder 2 yrs.	
19. MEDICAL CERTIFICATION		20. WAS AUTOPSY PERFORMED? Y YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1956, to Nov. 22, 1959, that I last saw the deceased alive on 11/22/59, 1959, and that death occurred at 1:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wilfred R. Ehrmantraut</i> , M.D. CHILDREN'S CENTER, LAUREL, MD. 11/24/59 ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		CHILDREN'S CENTER, LAUREL, MD. 11/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS D.T.S. Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Done, Jr. DT &amp; Laurel</i>		24a. REC'D. BY REGISTRAR NOV 27 '59	
		24b. REGISTRAR'S SIGNATURE <i>J. J. Done &amp; Sons</i>	

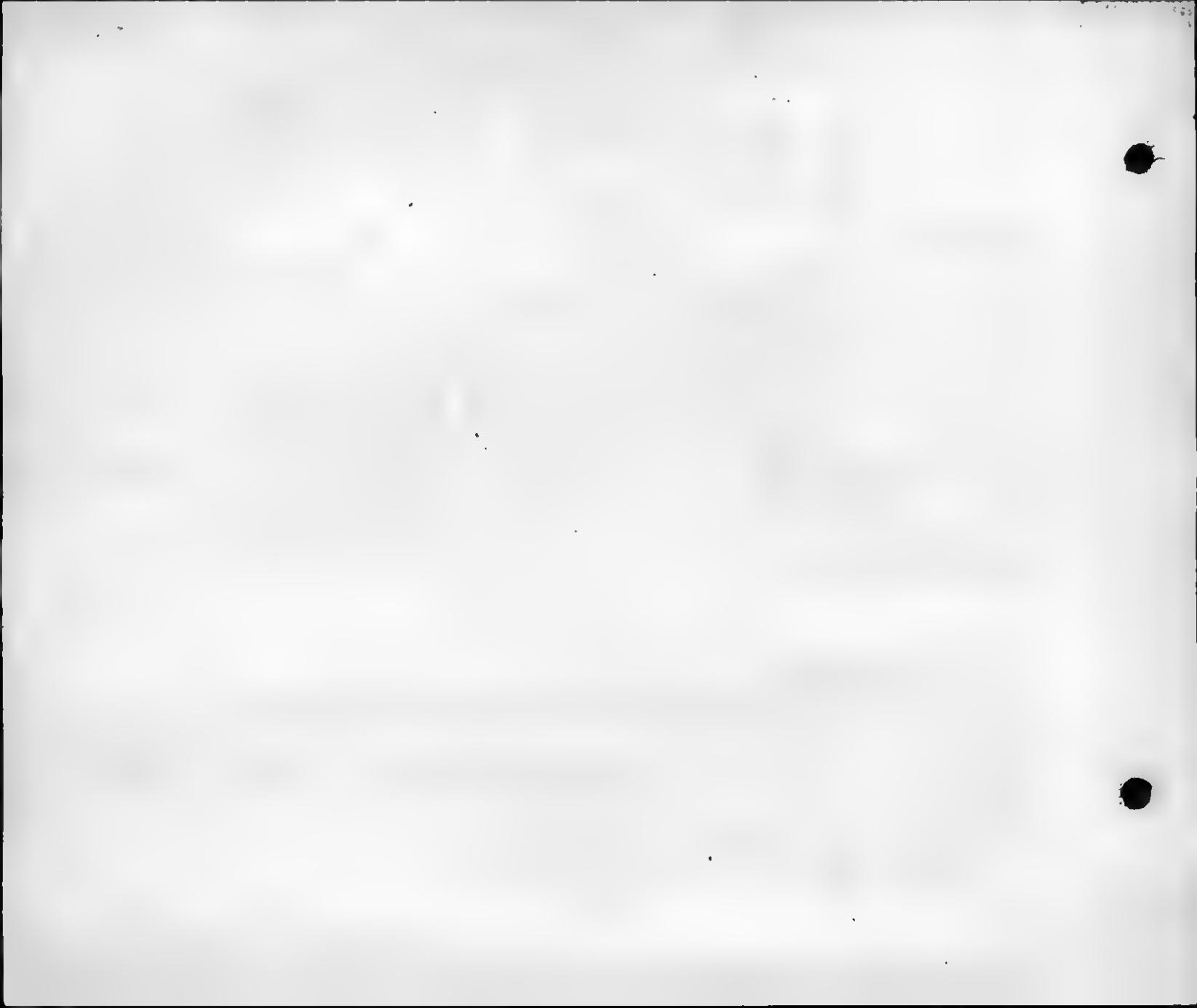


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 12 11. 02 2 11-16-59 et  
12179 CERTIFICATE OF DEATH

12146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b>		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>DA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN 50</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 RIVERSIDE Rd</b>		d. STREET ADDRESS <b>108 Riverside Rd</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS J. MC GUIGAN</b>		First <b>J.</b>	Middle <b>MC GUIGAN</b>
4. DATE OF DEATH <b>11-8-1959</b>		Month <b>11</b>	Day <b>8</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>OCT 29, 1888</b>		9. AGE (In years lost birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IRELAND</b>	10c. IF UNDER 24 HRS Hours <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Mc Guigan</b>		14. MOTHER'S MAIDEN NAME <b>Mc Donald</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-01-8797</b>	17. INFORMANT <b>Family</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>197X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Address <b>Some</b>	
19. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.      19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 8, 1959</b> to <b>Nov. 8, 1959</b> , that I last saw the deceased alive on <b>Nov. 8, 1959</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>3904 S. HANOVER ST. BALTO. MD.</b>	
ACTUAL SIGNATURE <b>Edgar S. Keane</b>		DATE SIGNED <b>11-10-59</b>	
PHYSICIAN'S NAME (Type) <b>Edgar S. Keane</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-11-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Cross Cemetery</b>
22d. LOCATION (City, town, or county) <b>BROOKLYN</b>		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCullough Funeral Home 130 E. Joliet</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Keane</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147

12180

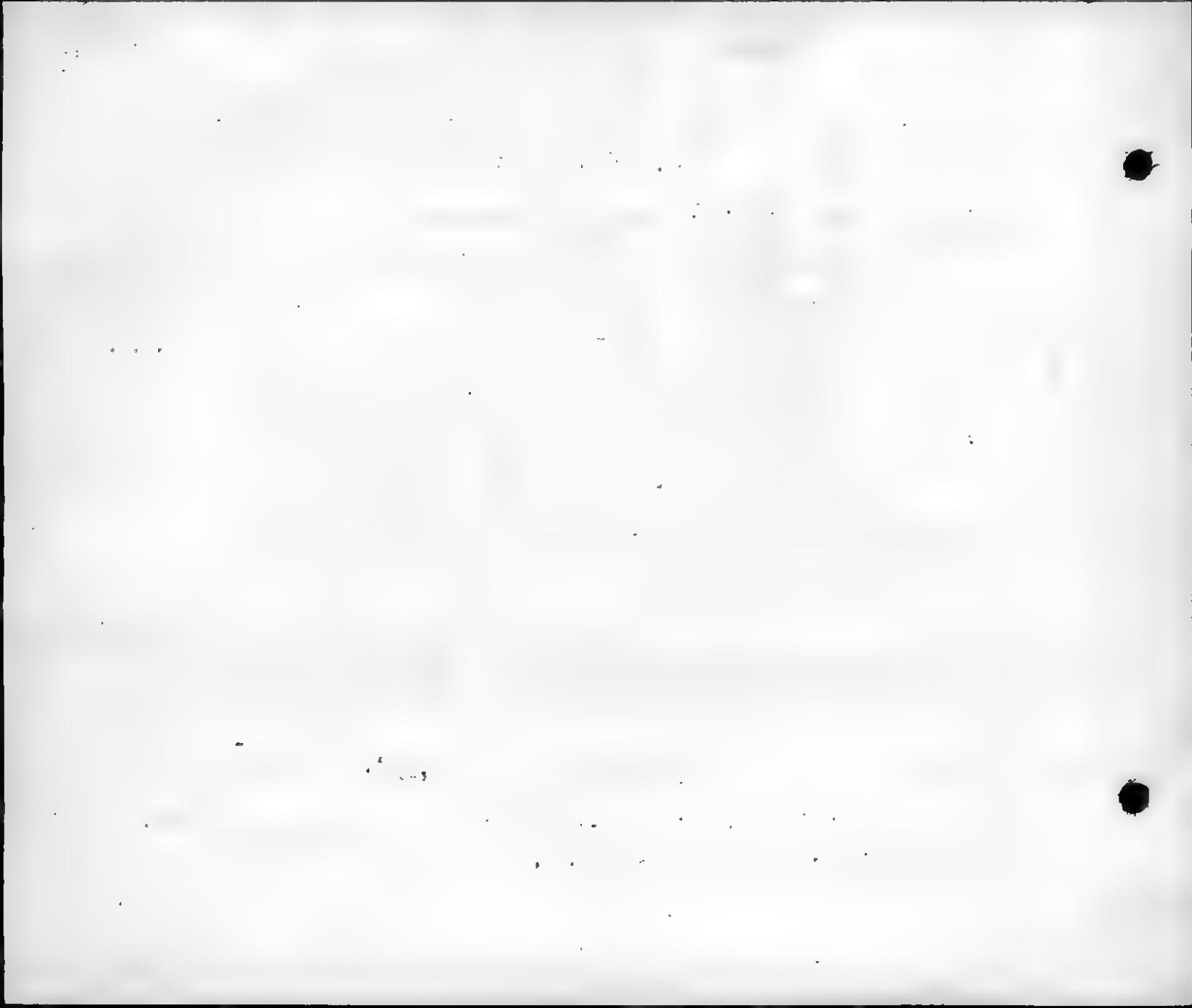
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b 2 years 7 mo. 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>Unknown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Sarah</b>	Middle	Last <b>Miles</b>	4. DATE OF DEATH	Month <b>11</b>	Day <b>12</b>	Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1885?</b>	9. AGE (In years last birthday) <b>74? yrs.</b>	IF UNDER 1 YEAR Months <b>74?</b>	IF UNDER 24 HRS Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Cerebral Thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Arteriosclerotic Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) -----						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. - - - 19 - p. m. - - - -		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) - - - - -		20f. (City or town) - - - - -		(County) - - - - -	(State) - - - - -
21. I certify that I attended the deceased from <b>3/16</b> , 19 <b>57</b> , to <b>11/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/12</b> , 19 <b>59</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above								ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>								H.D. <b>Crownsville State Hospital, Md. 11/12/59</b>	
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		Crownsville State Hospital, Md. 11/12/59							
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/16/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary Cem.</b>		22d. LOCATION (City, town, or county) <b>Cedar Hill, Md.</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Wilson</b>		ADDRESS <b>1000 Brantley Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>John Stevens</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

## CERTIFICATE OF DEATH

12148

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by him, it must be detached, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>	c. LENGTH OF STAY IN 1b <b>115 CHESTER AVE</b>	b. COUNTY <b>A.A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>A.A. GENERAL HOSPT.</b>	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>	d. STREET ADDRESS <b>115 CHESTER AVE</b>	
3. NAME OF DECEASED (Type or print) <b>FRANCIS A. MITCHELL</b>	First <b>FRANCIS</b>	Middle <b>A.</b>	Last <b>MITCHELL</b>
4. DATE OF DEATH <b>11 23 1959</b>	Month <b>11</b>	Day <b>23</b>	Year <b>1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>AUG 29 1916</b>
		WIDOWED <input type="checkbox"/>	4. AGE (In years (not birthday) yrs.) <b>43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.N.A.</b>	11. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>PHILLIP E. MITCHELL</b>	14. MOTHER'S MAIDEN NAME <b>ELSIE MAE DOWNEY</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	16. SOCIAL SECURITY NO <b>WWII</b>	17. INFORMANT <b>HELEN C. MITCHELL</b>	Address <b>#2</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inhalation, abdominal obstruction, ascites</b> DUE TO <b>D/I</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant invasion, abdominal viscera</b> DUE TO <b>3 yrs.</b> (c) <b>Lymphosarcoma, diffuse</b> DUE TO <b>4 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>121 CATHEDRAL ST. ANNAPOLIS, MD.</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 1959</b> , to <b>Nov. 23, 1959</b> , that I last saw the deceased alive on <b>Nov. 23, 1959</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Merton T. Waite</b>	ADDRESS (Street, city or town, state) <b>121 CATHEDRAL ST. ANNAPOLIS, MD.</b>	DATE SIGNED <b>11-23-59</b>	
PHYSICIAN'S NAME (Type) <b>MERTON T. WAITE</b>			
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>NOV 27 1959 HILL CREST MEM.</b>	22b. DATE THEREOF <b>NOV 27 1959</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>HILL CREST MEM.</b>	22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR - Son ANNAPOLIS MD</b>	ADDRESS <b>121 CATHEDRAL ST. ANNAPOLIS, MD.</b>	24a. REC'D BY REGISTRAR DATE <b>NOV 27 '59</b>	24b. REGISTRAR'S SIGNATURE <b>J. M. TAYLOR</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12149

12132

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fallen Farms, Md.</i>		c. LENGTH OF STAY IN lb <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>		STREET ADDRESS <i>72-W Washington Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>H. L. BERT</i>	Middle <i></i>	Last <i>Moberry</i>	4. DATE OF DEATH <i>Nov 11 1959</i>	Month <i>Nov</i>	Day <i>11</i>	Year <i>1959</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-20-1868</i>	9. AGE (In years last birthday) <i>90 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 MRS. Days <i></i>	12. IF UNDER 24 MRS. Hours <i></i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saltwater Shucker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland Oyster Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>John Moberry</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Moberry</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>214-12-6042</i>						
17. INFORMANT <i>SERIALINE Moberry</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Gastric Pulmonary Edema due to heart decompensation from long standing Cardiac disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>Serialine Moberry</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sensitivity</i>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>10/23/59</i> , 1959, to <i>11/11/59</i> , 1959, that I last saw the deceased alive on <i>11/11/59</i> , 1959, and that death occurred at <i>72-W Washington Street</i> , 1959, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. E. Richman, Esq.</i>		ADDRESS (Street, city or town, state) <i>110-Coffey St., Baltimore, Md.</i>		DATE SIGNED <i>11/11/59</i>								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial 11-14-59</i>		22b. DATE THEREOF <i>11-14-59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill Burial Park</i>		23. LOCATION (City, town, or county) <i>Baltimore, Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reesett, 108 Wash. St. Annapolis</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR NOV 17 '59		24b. REGISTRAR'S SIGNATURE <i>Albert &amp; Fina</i>						
VS A15 (4) 15M 9/55				DATE <i></i>								



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12133

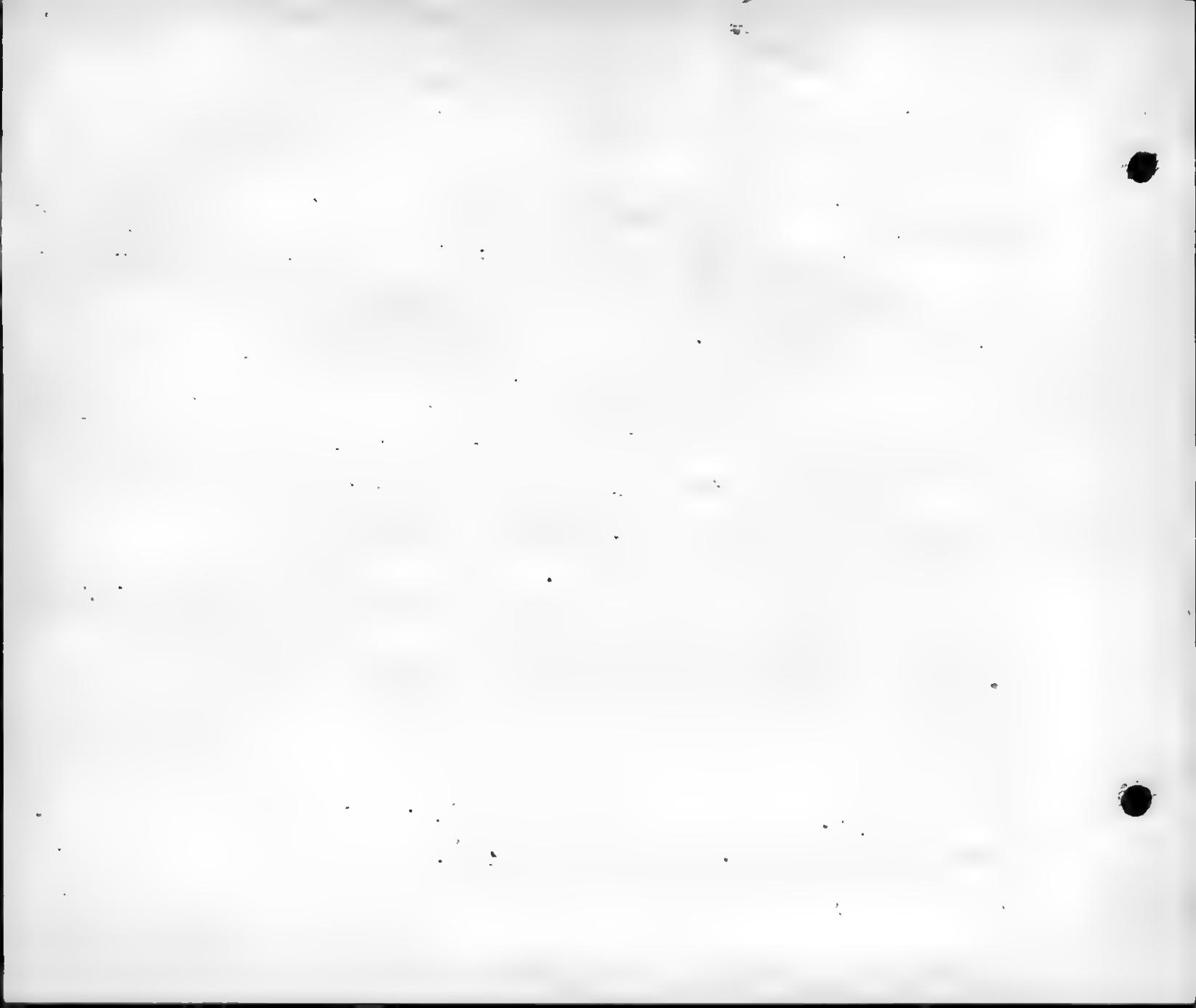
## CERTIFICATE OF DEATH

Reg. Dist. No.

12151

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Anne Arundel Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
c. LENGTH OF STAY IN 1b 15 days		d. STREET ADDRESS Silby on the Bay	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Berliah L. Mundell		4. DATE OF DEATH Nov. 25 <sup>th</sup> 1959	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/1883
9. AGE (In years last birthday) 76 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Riverview, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME James? Jones		
14. MOTHER'S MAIDEN NAME Editha Spencer	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO 577-50-3725		INFORMANT	Address above
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 3 weeks several years	
DUE TO Congestive heart failure Hypertensive cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1959, to Nov. 25, 1959, that I last saw the deceased alive on Nov. 25, 1959, and that death occurred at 10:50 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Sylvia M. Lewis, M.D., Edgewater, Md.	
ACTUAL SIGNATURE Sylvia M. Lewis, M.D.		DATE SIGNED 11-26-59	
PHYSICIAN'S NAME (Type) Sylvia M. Lewis		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 11/28/59		22c. NAME OF CEMETERY OR CREMATORIUM Congressional Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Mallory's Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE NOV 30 1959	
ADDRESS Multi Rainier, Md.		24b. REGISTRAR'S SIGNATURE C. Lewis S. Kraus	

**TO HOSPITAL OR HOSPITAL** may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12152

12134

## CERTIFICATE OF DEATH

Reg. Dist. No.

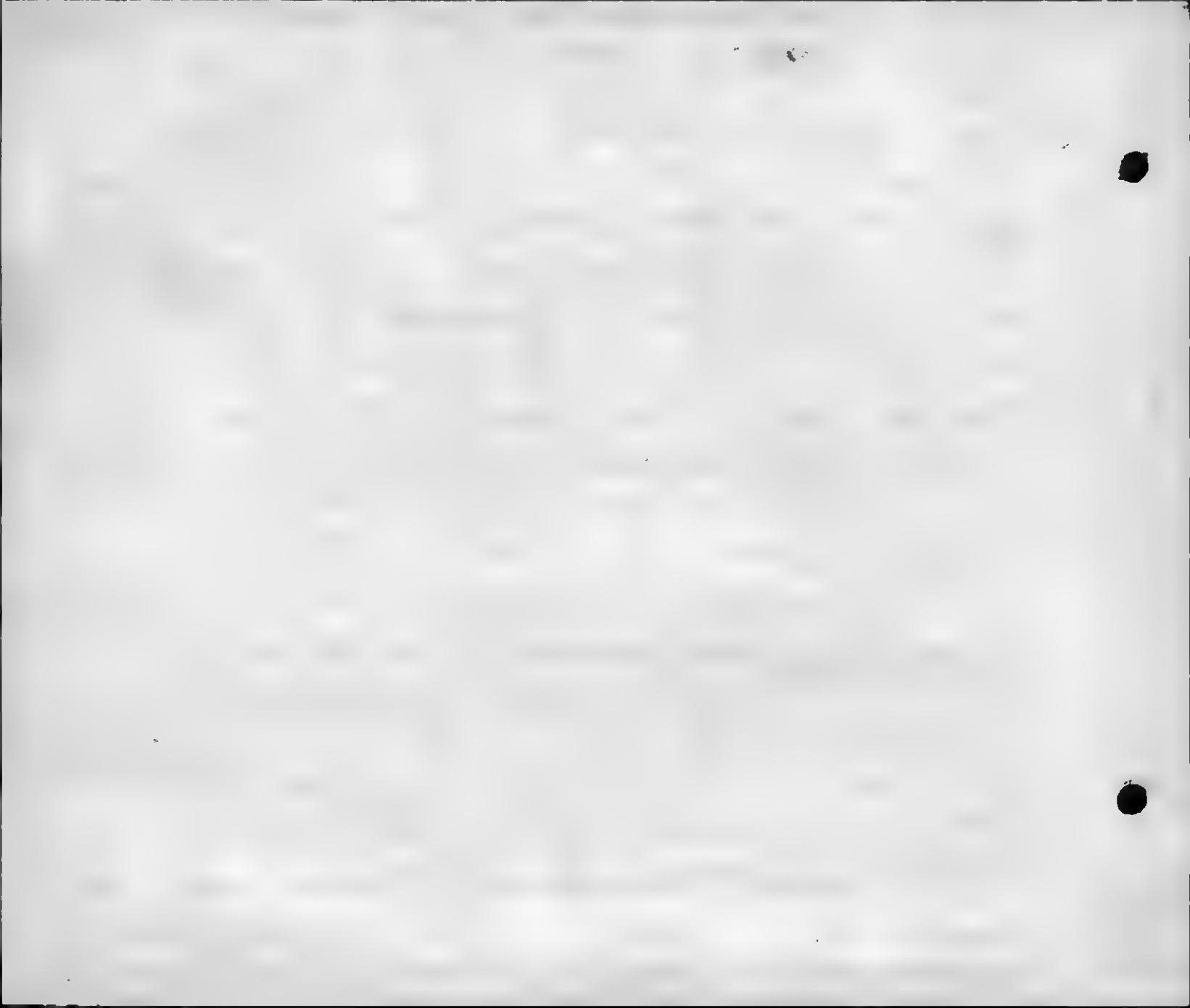
1. PLACE OF DEATH o COUNTY  Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Annapolis	c. LENGTH OF STAY IN lb  1 hour	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural - Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Anne Arundel General Hospital		d. STREET ADDRESS  Revell Highway	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)  JACOB	First  DONALDSON	Middle  PARR	4. DATE OF DEATH Month November Day 20 Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1906
9. AGE (In years 1st birthday) 53 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Promoter	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.	13. FATHER'S NAME Jacob S. Parr		
14. MOTHER'S MAIDEN NAME Sarah Delcher	15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Nancy Anne Parr-Annapolis, Maryland Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Deutsche myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO <i>Coronary artery sclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 5 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Anne</i> , 1955, to <i>Nov</i> , 1959, that I last saw the deceased alive on <i>Nov 20</i> , 1959, and that death occurred <i>11:50 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John L. Hedeman</i>	M.D.	11/20/59	
PHYSICIAN'S NAME (Type) John L. Hedeman	Annapolis, Md.		
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	22d. LOCATION (City, town, or county) Woodlawn, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Beckwith</i>	ADDRESS <i>McAfee Building</i>	24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>

2017

4

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

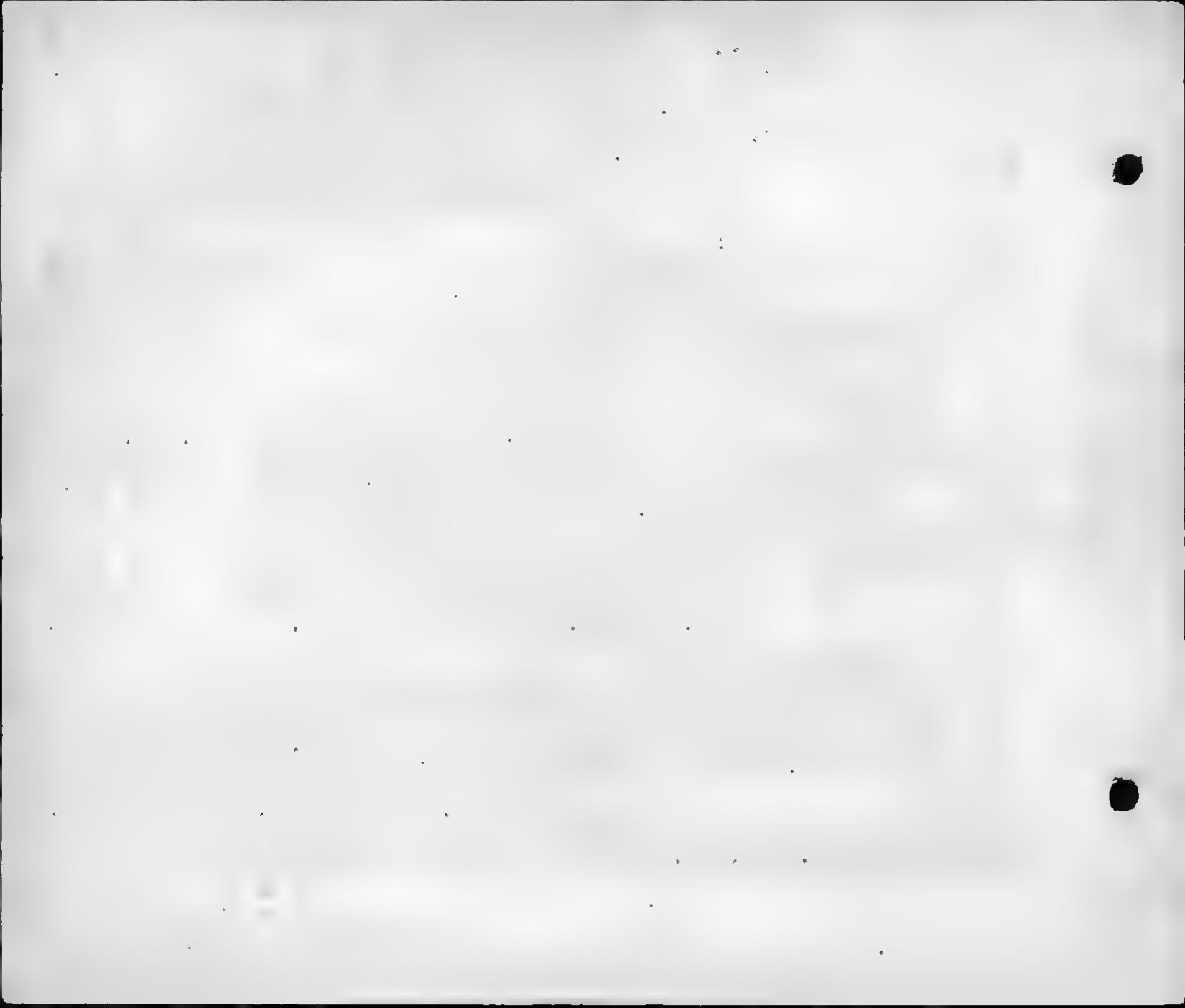
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 12153
12135 CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY 4. + MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY MD					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 3 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS					
d. NAME OF HOSPITAL (If not in hospital, give street address) 513 - 5th Street		d. STREET ADDRESS 513 - 5th Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Charles Ferguson		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
5. SEX M		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5-85	9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MD		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Julia Crowley								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 314-65-2392		17. INFORMANT Felix J. Ferguson		Address 11-29-58				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO		Diseasewna Slownach				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 11-28-58, 19, to 11-29-58, 19, that I last saw the deceased alive on 11-28-58, 19, and that death occurred at 5 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE G. T. Cates		M.D. 62 Cathedral St								
PHYSICIAN'S NAME (Type) A T ALLEN		Annapolis, Md								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-58		22c. NAME OF CEMETERY OR CREMATORIAL ANNAPOLIS Mech Av. Annapolis, Md		22d. LOCATION (City, town, or county) Annapolis, Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Allen		ADDRESS 415-4th Street - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 2 D, File No. 11/13/59, Iwk 12181 CERTIFICATE OF DEATH										Reg. Dist. No. 12154
1. PLACE OF DEATH a. COUNTY Anne Arundel Co. Md. MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Glen-burnie		c. LENGTH OF STAY IN 1b 9 Mo.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen-Burnie					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Convalescent Home					d. STREET ADDRESS None 1046 Pennsylvania Ave Balto. D. Md.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Mary	Middle Clara	Last Powell	4. DATE OF DEATH Nov. 20, 1959	Month Nov.	Day 20	Year 1959		
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1895			9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY NONE			11. BIRTHPLACE (State or foreign country) Anacostia, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Charles Thompson					14. MOTHER'S MAIDEN NAME Delia Thompson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Cherry Powell 1648 Penna. Ave.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with aortic</u> <u>stenosis.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 ? yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Adenocarcinoma of thyroid, probable. Chronic brain syndrome.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 5, 1959</u> , to <u>November 9, 1959</u> , that I last saw the deceased alive on <u>November 7, 1959</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>James M. Pair</u> M.D. 400 N. Carrollton Ave. November 10, 1959 ADDRESS (Street, city or town, state) DATE SIGNED										
PHYSICIAN'S NAME (Type)		Baltimore 23, Maryland								
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn Cemetery			22d. LOCATION (City, town, or county) Baltimore, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson 916 Penna. Ave.					24a. REC'D. BY REGISTRAR NOV 12 1959 DATE					24b. REGISTRAR'S SIGNATURE C. L. Turner



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12182

## CERTIFICATE OF DEATH

12155

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trait permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>		c. LENGTH OF STAY IN 1b <i>life time</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>A. G.</i>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Shady Side</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Fredes Edmund</i>		Middle <i>Proctor</i>		4. DATE OF DEATH <i>November 23 1959</i>		Month Day Year	
S SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/17/96</i>	9. AGE (in years last birthday) <i>63 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sea Food</i>		11. BIRTHPLACE (State or foreign country) <i>Shadyside Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i>			
13. FATHER'S NAME <i>George Westey Proctor</i>				14. MOTHER'S MAIDEN NAME <i>Ida Virginia Lee</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>WWI</i>		17. INFORMANT <i>Lucy A Proctor Shadyside Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>161X</i>		DUE TO <i>Carcinoma of larynx</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>DUE TO</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Shady Side, Md.</i>		20f. (City or town) <i>(County)</i> <i>(State)</i>			
21. I certify that I attended the deceased from <i>March</i> , 1959, to <i>Nov. 23</i> , 1959, that I last saw the deceased alive on <i>Nov. 23</i> , 1959, and that death occurred at <i>115 p.m.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Shady Side, Md.</i>							
ACTUAL SIGNATURE <i>Willard F. Smith</i>		DATE SIGNED <i>11/24/59</i>							
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/27/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON National / Fort Myer, Va</i>		22d. LOCATION (City, town, or county) <i>(State)</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardy Galesville Md</i>		ADDRESS <i>ADDRESS</i>		24a. REC'D BY REGISTRAR <i>NOV 30 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Carroll S. Krause</i>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health.

10. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

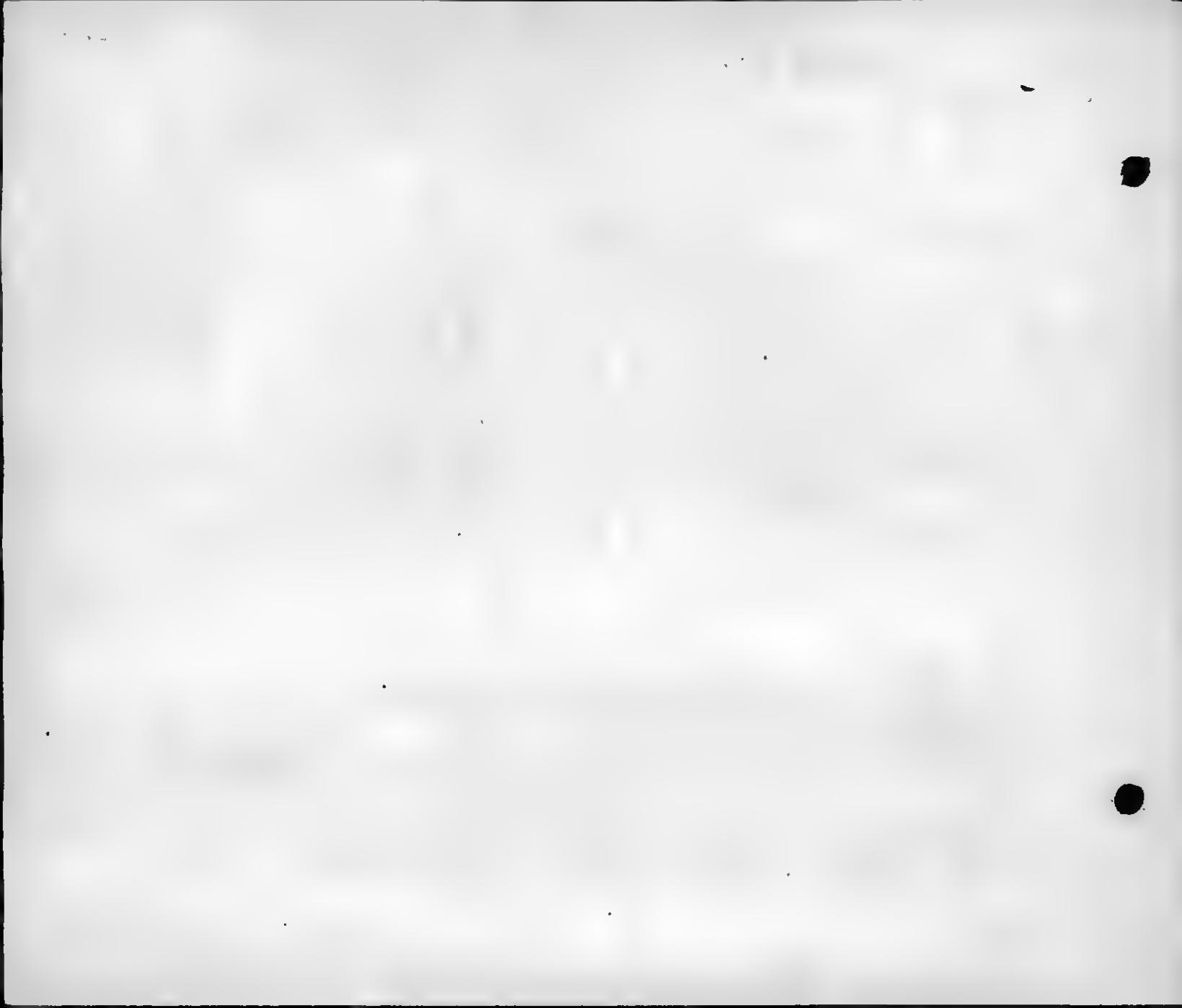
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VIRGINIA b. COUNTY NORFOLK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN		c. LENGTH OF STAY IN 1b FEW MINUTES	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 554 ON WAY TO FGGM HOSPITAL			
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle QUIGLEY	4. DATE OF DEATH NOV 1 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 27, 1938	9. AGE (In years last birthday) 21 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Naval dental tech.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Lansing, Michigan	
13. FATHER'S NAME Donald Quigley		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) In US Navy at present		16. SOCIAL SECURITY NO. 376-38-3756	17. INFORMANT RICHARD JAMES OSTHEIM (FRIEND)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		Address INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car ran off road and turned over.	
20c. TIME OF INJURY Hour 1130 p.m.	Month, Day, Year Oct 31 1959	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 554
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) SEVERN (County) A A COUNTY (State) MD.	
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1 Nov 59
EXAMINER'S NAME (Type) GUSTAVE H. FAUBERT	22b. DATE THEREOF 11/3/59	22c. NAME OF CEMETERY OR CREMATORIUM Lansing	22d. LOCATION (City, town, or county) Michigan
22a. BURIAL CREMATION, REMOVAL (Specify) Kenzekal	22e. ADDRESS 621 1/2 Ma.	24a. REC'D BY REGISTRAR DATE NOV 3 '59	24b. REG STAR'S SIGNATURE <i>Arthur S. Thomas</i>
23. FUNERAL DIRECTOR'S SIGNATURE 621 1/2 Ma.			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

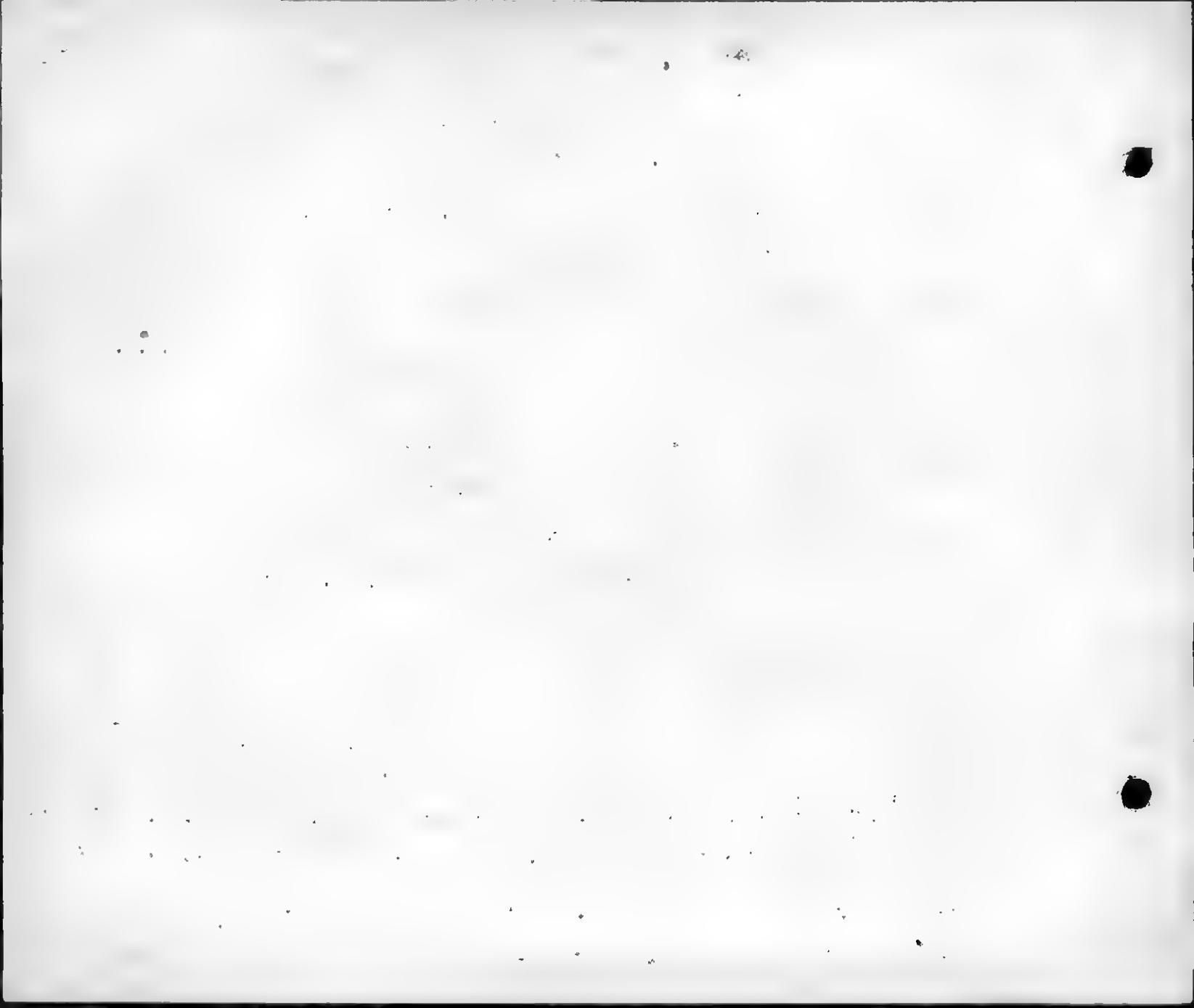
12184

## CERTIFICATE OF DEATH

Reg. Dist. No.

12157

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1mo. 17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>219 E. Federal Street</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <b>Richard</b>	Middle 	Last <b>Rice</b>	4. DATE OF DEATH <b>11</b>	Month <b>11</b>	Day <b>11</b>	Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1900</b>	9. AGE (In years lost birthday) <b>59</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? {Yes, no, or unknown} <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Bronchopneumonia</b> DUE TO <b>020.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO <b>Bulbar Paralysis</b> (b) DUE TO <b>Congenital Syphilis with Gumma of Brain</b> (c)										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----								
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. --- 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -		20f. (City or town) - - -		(County) - - -	(State) - - -	
21. I certify that I attended the deceased from <b>9/24</b> , 19 <b>59</b> , to <b>11/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/11</b> , 19 <b>59</b> , and that death occurred at <b>9:30P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>11/12/59</b>								
ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i>		Crownsville State Hospital, Md. 11/12/59								
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>		Crownsville State Hospital, Md. 11/12/59								
22a. BURIAL, CREMATION, NOVIAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-16-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arbutus Mem. Park</b>		22d. LOCATION (City, town, or county) <b>Arbutus</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Milton E. Eichman - 1129 N. Carolina St.</b>		ADDRESS <b>1129 N. Carolina St.</b>		24a. REC'D'DY REGISTRAR <b>NOV 18 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12136

## CERTIFICATE OF DEATH

Reg. Dist. No.

12158

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Anne Arundel Maryland		a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY A.H.-Co.		
Annapolis	LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
15 EASTERN AVE.	15 EASTERN AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First C.	Middle CORNER	Last Ridout	
4. DATE OF DEATH	Month 11	Day 1	Year 1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-1891	
9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY Clothing Store	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES Ridout	14. MOTHER'S MAIDEN NAME C. ARRIE CORNER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO		17. INFORMANT Niva P. Ridout # 2	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 (b) Atherosclerotic coronary artery dis. 10 year's DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-1959 to 11-1-1959, that I last saw the deceased alive on 11-1-1959, and that death occurred at 11:30 P.M., from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Edward S. Becker</i>	M.D.	ADDRESS (Street, city or town, state) 41 Southgate Ave 112457 Annapolis MD	DATE SIGNED 11/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-4-59	22c. NAME OF CEMETERY OR CREMATORIUM St. MARGARET'S	22d. LOCATION (City, town, or county) St. MARGARET'S Mo.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Gibbons Annapolis, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR NOV 4 '59 DATE	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12185

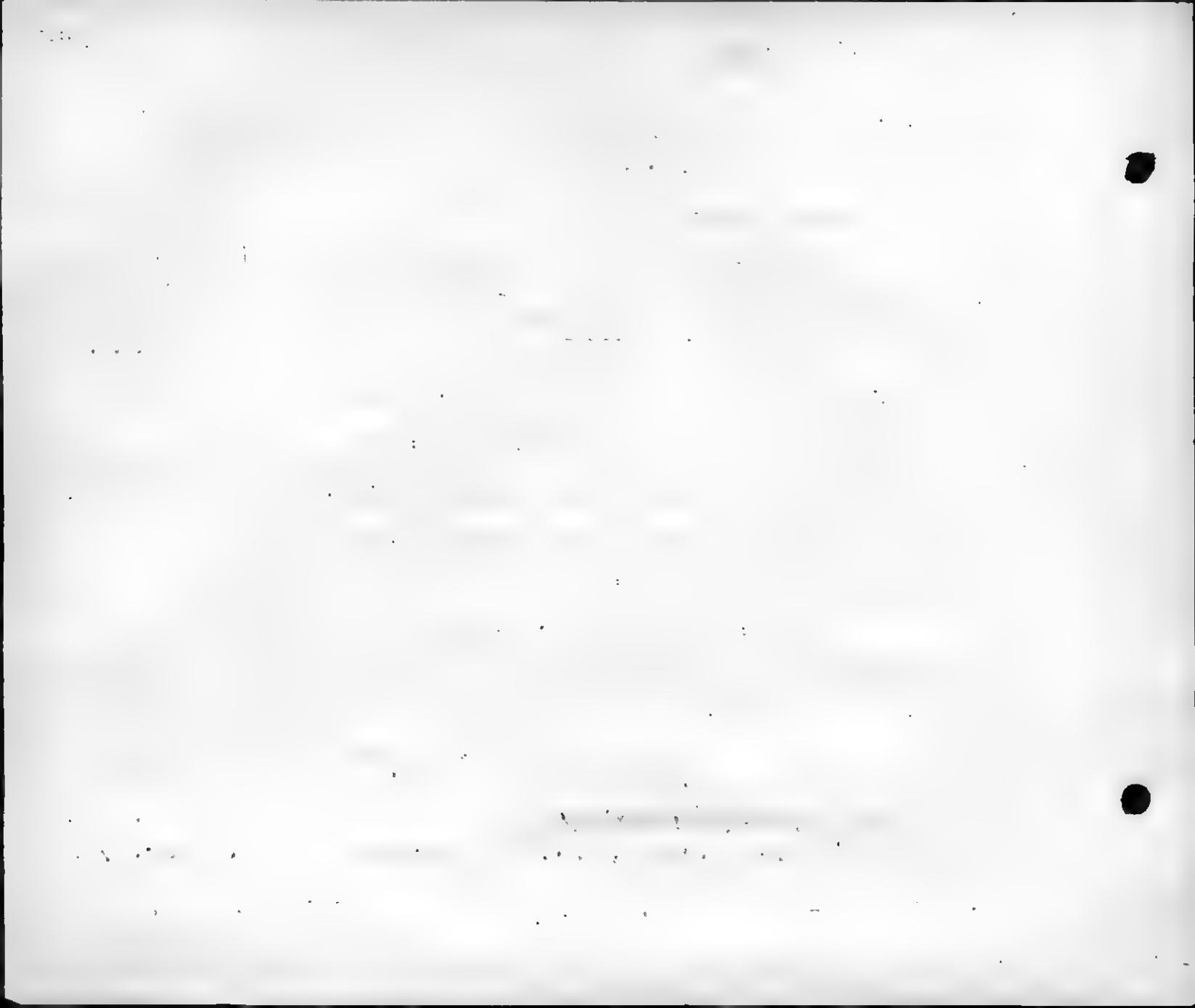
## CERTIFICATE OF DEATH

Reg. Dist. No.

12159

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c LENGTH OF STAY IN 1b <b>7 years 4 mo. 13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 V 21-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d STREET ADDRESS <b>713 Brune Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ada</b>	Middle	Last <b>Robinson</b>	4. DATE OF DEATH <b>10</b>	Month	Day <b>6</b>	Year <b>19 59</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>1900</b>	9. AGE (In years last birthday) <b>59</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Bell</b>				14. MOTHER'S MAIDEN NAME <b>Sally Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombophlebitis of vena cava inferior with complete occlusion</b> <b>605X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Thrombophlebitis of vesical plexus</b> (c) <b>Purulent cystitis and ureteritis</b> INTERVAL BETWEEN ONSET AND DEATH -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>023</b> <b>Syphilitic cardiovascular disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>-</b> 19 p.m. <b>-</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) - - -		20f. (City or town) - - -	(County) <b>-</b> (State) <b>-</b>
21. I certify that I attended the deceased from <b>5/23</b> , 19 <b>52</b> , to <b>10/6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/6</b> , 19 <b>59</b> , and that death occurred at <b>6:35A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>							
DATE SIGNED <b>10/6/59</b>							
ACTUAL SIGNATURE <b>Hildegard Heard Reissman, M.D.</b>		Crownsville State Hospital, Md. <b>10/6/59</b>					
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.D.</b>		Crownsville State Hospital, Md. <b>10/6/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Auburn Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frances J. Kennedy</b>		ADDRESS <b>578 W Bristol</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12160

12186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Geo G. Meade	c. LENGTH OF STAY IN 1b 30 minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bldg. 9800 Savage Road NSA Oper. Bldg.		d. STREET ADDRESS 4709 Blackfoot Road	
3. NAME OF DECEASED (Type or print)  BENJAMIN	First D.	Last SCHULTZ	4. DATE OF DEATH Month November Day 10 Year 1959
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4 1894
		9. AGE (in years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Foreman		10b. KIND OF BUSINESS OR INDUSTRY U S Government	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Joseph Schultz		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 106-09-8811	17. INFORMANT Mr. James C. Stanier
		Address NSA Oper. Bldg.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
4/20/59 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert, MD</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10 Nov 59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 16, 1959	22c. NAME OF CEMETERY OR BURIAL SITE Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Maryland.	24a. REC'D BY REGISTRAR DATE NOV 13 '59
			24b. REGISTRAR'S SIGNATURE <i>Calvin L. Krause</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "Pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12137

## CERTIFICATE OF DEATH

12161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>E. ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>E. ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS, MD.</b>		c. LENGTH OF STAY IN 1b <b>1½ hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNA. OLLIS, MARYLAND</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>NAVAL HOSPITAL</b>				d. STREET ADDRESS <b>19 Goodrich Rd.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BABY GIRL</b>		First <b>SC' URR</b>	Middle	Last	4. DATE OF DEATH Month <b>11</b>	Day <b>13</b>	Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-59</b>	9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS. Days <b>1</b>	Hours <b>1</b>	Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Thomas Paul SCHURR</b>				14. MOTHER'S MAIDEN NAME <b>Vilma D'AVI</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (F) T.P. SCHURR, 19 Goodrich Rd.,		Address <b>Annapolis, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  <b>b</b> DUE TO <b>c</b>				DIAPHRAGMATIC HERNIA		INTERVAL BETWEEN ONSET AND DEATH <b>1</b>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				NO AUTOPSY DONE-SURGERY WAS PERFORMED		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>		20f. (City or town) <b>ANNAPOLIS</b>		(County) <b>ANNAPOLIS</b>	(State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>21-29 11-13 1957</b> , to <b>23-30 11-13 1957</b> , that I last saw the deceased alive on <b>11-13 1957</b> , and that death occurred at <b>23-30 11-13 1957</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>F. M. KENNY</b>									
PHYSICIAN'S NAME (Type) <b>F. M. KENNY LT MC USNR</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-16-59</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Naval Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gwen M. Taylor Son</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 20 1959</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Tracy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 3 should be forwarded for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12138

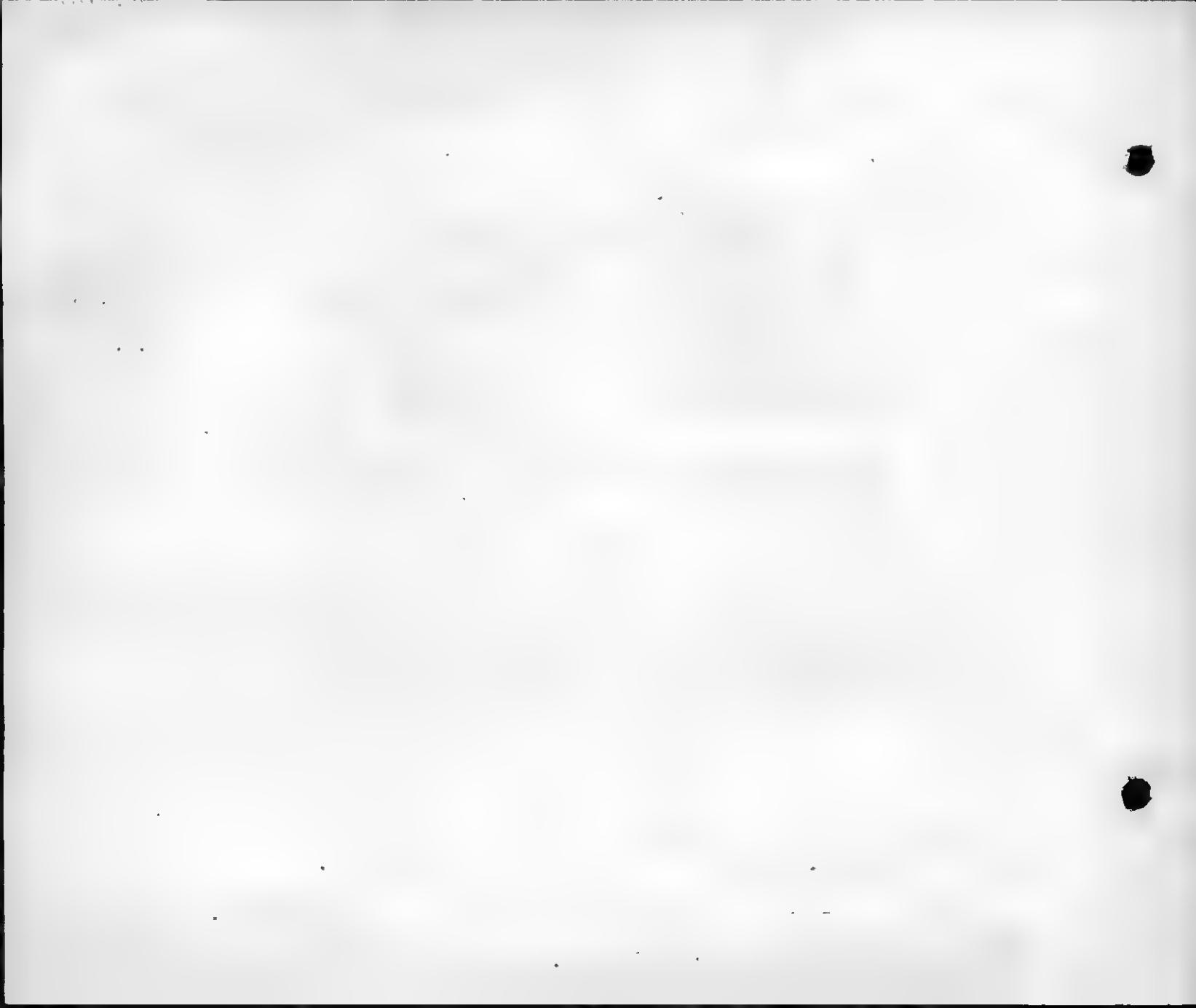
## CERTIFICATE OF DEATH

12162

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>UNNAMED</b>	Middle <b>SCHUTTENHELM</b>	4. DATE OF DEATH Month <b>November</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Year <b>November 19, 1959</b>
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10. AGE (In years last birthday) yrs. <b>20</b>	11. IF UNDER 1 YEAR Months <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Roger Edward SCHUTTENHELM</b>		14. MOTHER'S MAIDEN NAME <b>Jane Sophie KRAUS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (b). <b>Prematurity</b> INTERVAL BETWEEN ONSET AND DEATH  776X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 19</b> , 1959, to <b>Nov 20</b> , 1959, that I last saw the deceased alive on <b>Nov 19</b> , 1959, and that death occurred at <b>6:25A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>95 Cathedral St., Annapolis, Md.</b>			
ACTUAL SIGNATURE <b>Neil H. Sims</b>		DATE SIGNED <b>11/20/59</b>	
PHYSICIAN'S NAME (Type) <b>Neil H. Sims</b>		Ann Arbor, Michigan	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-21-59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Hillcrest Memorial</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	
		24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12187

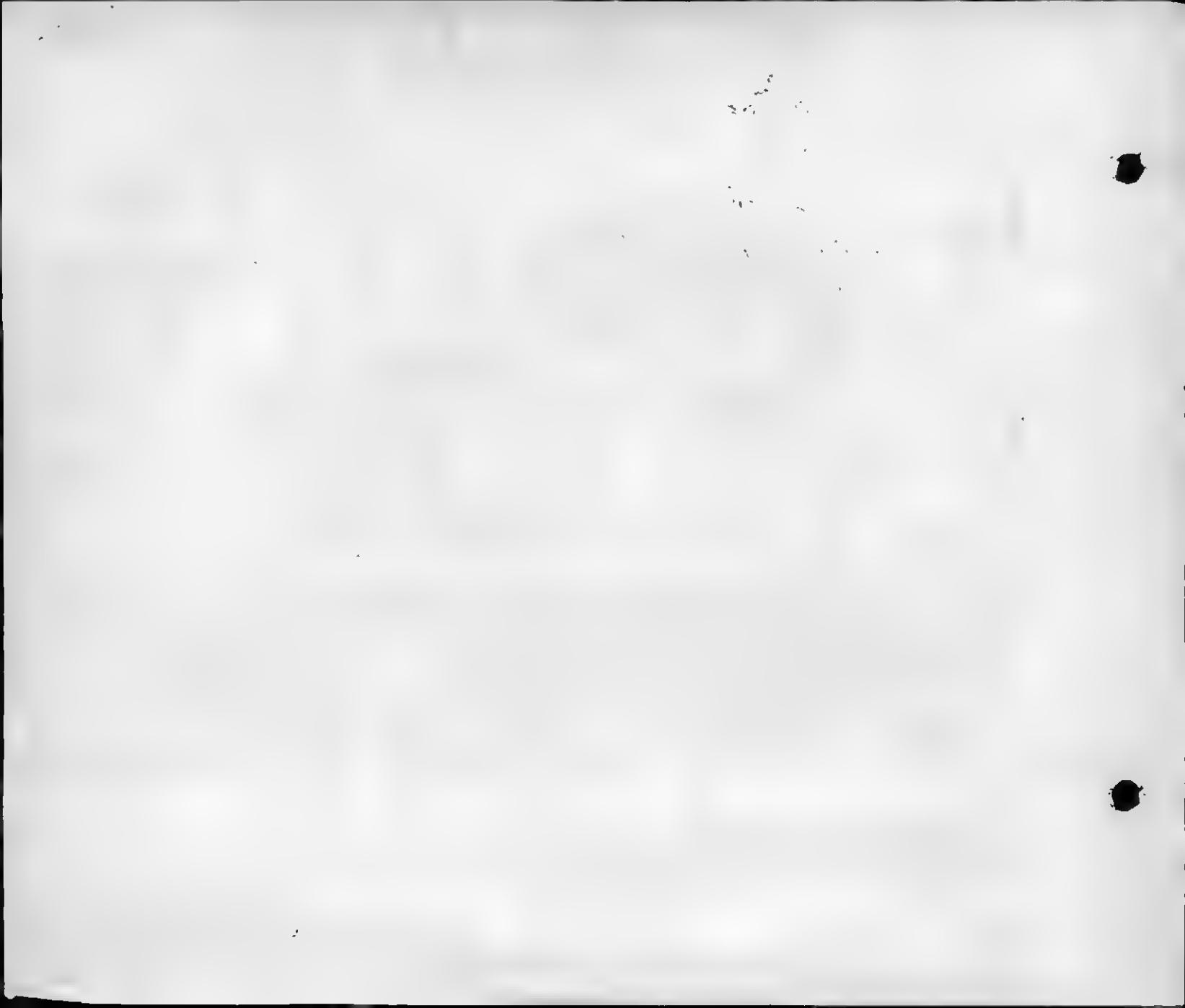
## CERTIFICATE OF DEATH

12163

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MARGARET'S</b>		c. LENGTH OF STAY IN 1b <b>REVELL HIGHWAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REVELL HIGHWAY</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MARGARET'S</b>			
f. STREET ADDRESS <b>REVELL HIGHWAY</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY MAUDE Minnick Scott</b>		4. DATE OF DEATH Month <b>11</b>	Day Year <b>26 1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>LL</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-19-1881</b>		
9. AGE (In years lost birthday) yrs. <b>78</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOLISE WIFE</b>	11. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>GEORGE R. Minnick</b>	14. MOTHER'S MAIDEN NAME <b>PATRICIA STALER</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>443X</b>			
16. SOCIAL SECURITY NO. <b>1-1-1-1-1-1-1-1</b>	17. INFORMANT <b>J. CARROLL Scott #2</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac Failure</b> DUE TO <b>about 6 hr</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cronic Arterial Hypertension</b> DUE TO <b>many yrs.</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>40 Franklin St.</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Nov 9<sup>th</sup></b> , 1959, to <b>Nov 26</b> , 1959, that I last saw the deceased alive on <b>Nov 26</b> , 1959, and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. OLIVER PURVIS</b> M.D. ADDRESS (Street, city or town, state) <b>40 Franklin St., Baltimore, Md.</b> DATE SIGNED <b>11/27/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-29-59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>ST. MARGARET'S</b>	22d. LOCATION (City, town, or county) <b>ST. MARGARET'S</b>	(State) <b>Md.</b>	
22e. FUNERAL DIRECTOR'S SIGNATURE <b>John J. O'Farrell, Crematory, Md.</b>	22f. ADDRESS <b>Arthur S. Turner</b>	24a. REC'D BY REGISTRAR <b>DEC 1 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Turner</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12139

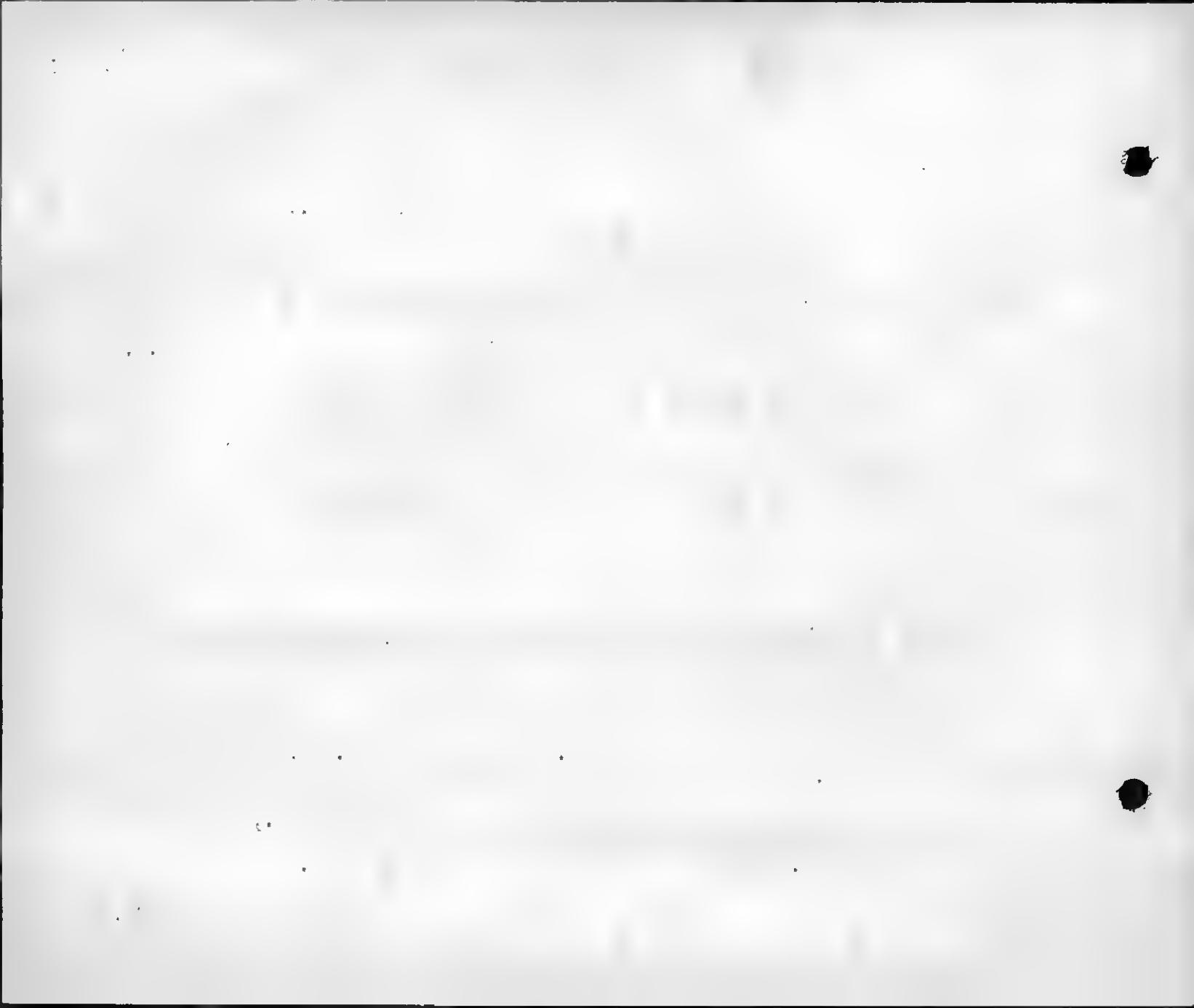
## CERTIFICATE OF DEATH

Reg. Dist. No.

12164

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived—if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>C</b>	Last <b>SELLERS</b>
4. DATE OF DEATH <b>November</b>	Month <b>25</b>	Day <b>19</b>	Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 8, 1891</b>
9. AGE (in years last birthday) <b>68 yrs.</b>	10. IF UNDER 1 YEAR Months <b>68</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>E. J. Dugan</b>		14. MOTHER'S MAIDEN NAME <b>McKinnon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Howard Sellers</b> Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADRENAL INSUFFICIENCY</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CELLULITIS OF BUTTOCKS</b> DUE TO (c) <b>DIABETES MELLITUS</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>48 Hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ACUTE RHEUMATIC ARTHRITIS; ACUTE GASTROENTERITIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 22, 1959</b> , to <b>Nov. 24, 1959</b> , that I last saw the deceased alive on <b>Nov. 24, 1959</b> , and that death occurred at <b>6:05A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>41 Southgate Ave., Annapolis, Md.</b> DATE SIGNED <b>11/25/59</b>			
ACTUAL SIGNATURE <b>Edward S. Beck</b>			
PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>		Ann Arbor, Michigan	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Floral Park</b>		22d. LOCATION (City, town, or county) <b>Indianapolis, Ind.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Layton Sons</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knobell</b>	



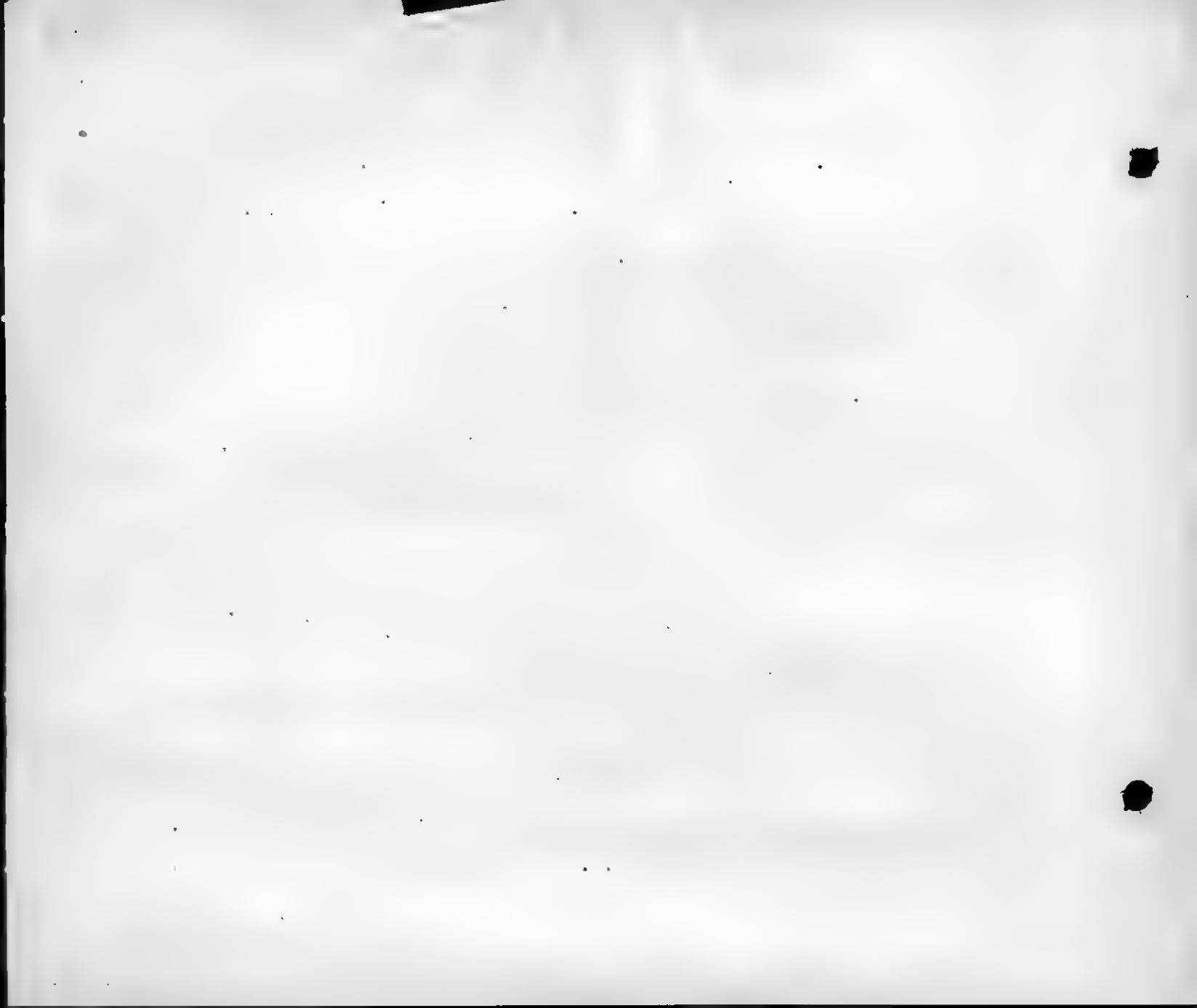
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12165

## 12188 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2 USUAL RESIDENCE [Where deceased lived. If institution Residence before admission] a. STATE b. COUNTY	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Laurel, Md.		c. LENGTH OF STAY IN 1b 29 years		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Washington, D.C. 44 X 7	
d. NAME OF HOSPITAL [If not in hospital, give street address or institution] Children's Center District Training School		e. STREET ADDRESS Laurel, Md. 923 Shepherd Street N.W.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED [Type or print] Paul		First J.	Middle Sexton	4. DATE OF DEATH November 17, 1959	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1899	9. AGE (In years lost birthday) 60 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] Institution		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE [State or foreign country] North Dakota	
13. FATHER'S NAME Edward J. Sexton		14. MOTHER'S MAIDEN NAME Margaret		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO —		17. INFORMANT Children's Center, Laurel, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Bronchial asthma, hypoglycemia, edema				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Name of injury in Part I or Part II of item 18] —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1956</u> to <u>Nov 17, 1959</u> that I last saw the deceased alive on <u>Nov 17, 1959</u> and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D. Children's Center, Laurel, Md. 11/18/59 ADDRESS (Street, city or town, state) DATE SIGNED 11/18/59					
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.		Children's Center, Laurel, Md. 11/18/59			
22a. BURIAL, Cremation, Removal (Specify) 11/19/59		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORIUM DTS Cemetery	
22d. LOCATION (City, town, or county) Laurel, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Done, Jr. D.S.L. DTS Laurel, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 25 1959	
				24b. REGISTRAR'S SIGNATURE Crisco & Kline	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12166

12140

## CERTIFICATE OF DEATH

Reg. Dist. No.

<p><input checked="" type="checkbox"/> HOSPITAL OR ATTENDANT <input type="checkbox"/> PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. <input type="checkbox"/> Hospital or attending physician may be retained by the hospital or attending physician.</p> <p><input type="checkbox"/> TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.</p>			
<p>1. PLACE OF DEATH        a. COUNTY Anne Arundel MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville 4 mo. 1 day</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital</p>			
<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Anne Arundel</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn</p>			
<p>3. NAME OF DECEASED First Edward Middle Smith</p> <p>4. DATE OF DEATH Month 11 Day 18 Year 1959</p>			
<p>5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED</p> <p>8. DATE OF BIRTH July 7, 1901 9. AGE (In years lost birthday) 58 yrs.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed</p> <p>10b. KIND OF BUSINESS OR INDUSTRY -----</p> <p>11. BIRTHPLACE (State or foreign country) Maryland</p>			
<p>12. CITIZEN OF WHAT COUNTRY U.S.A.</p>			
<p>13. FATHER'S NAME Tom Smith 14. MOTHER'S MAIDEN NAME Ella</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 217-09-8984 17. INFORMANT Hospital Records Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia INTERVAL BETWEEN ONSET AND DEATH</p> <p>21a X DUE TO Arteriosclerotic Cardiovascular Disease</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) -----</p> <p>DUE TO Diabetes Mellitus (c) -----</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome Associated with Metabolism Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----</p>			
<p>20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)</p> <p>Hour o. m. - - - 19 -----</p>			
<p>21. I certify that I attended the deceased from 7/17, 1959, to 11/18, 1959, that I last saw the deceased alive on 11/18, 1959, and that death occurred at 3:30 P.M. from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) M.D. Crownsville State Hospital, Md. 11/19/59 DATE SIGNED</p> <p>ACTUAL SIGNATURE Hildegard Heard Reissman, M.D. Hildegard Heard Reissman, M.D. 11/19/59</p> <p>POLAROID</p> <p>POLAROID</p> <p>POLAROID</p>			
<p>22a. BURIAL CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Burial Nov. 23, 1959 Arbuthus Memorial Pk. Baltimore Co. Md.</p>			
<p>22d. LOCATION (City, town, or county) (State)</p>			
<p>23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Home 24a. REC'D BY REGISTRAR Date NOV 23 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Mann</p> <p>Jane Clark Funeral Home 1031 Grand Hill Ave.</p>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 12167	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo			d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION											
3. NAME OF DECEASED (Type or print)		First Lewis	Middle H.	Last Smith	4. DATE OF DEATH NOV. 23		Month	Day	Year 1959		
5. SEX Male		16. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 28. 1885		9 AGE (In years (1st birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret			10b. KIND OF BUSINESS OR INDUSTRY Printer			11. BIRTHPLACE (State or foreign country) Miss.			12 CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edwaed H. Smith			14. MOTHER'S MAIDEN NAME Mary. Dilly								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			INFORMANT Richard. Smith			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH, 3 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office b dg. etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>Oct. 30, 1959</u> , to <u>Oct. 28, 1959</u> , that I last saw the deceased alive on <u>Nov. 23, 1959</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Sylvia M. Lewis</u> M.D. ADDRESS (Street, city or town, state) <u>Edgewater, Md.</u> DATE SIGNED <u>11-23-59</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11.25.59		22c. NAME OF CEMETERY OR CREMATORIUM Fort. Lincoln			22d. LOCATION (City, town or county) Colmar. Manor			(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home				ADDRESS 300.4th st N.E.			24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Anna		
							DATE				

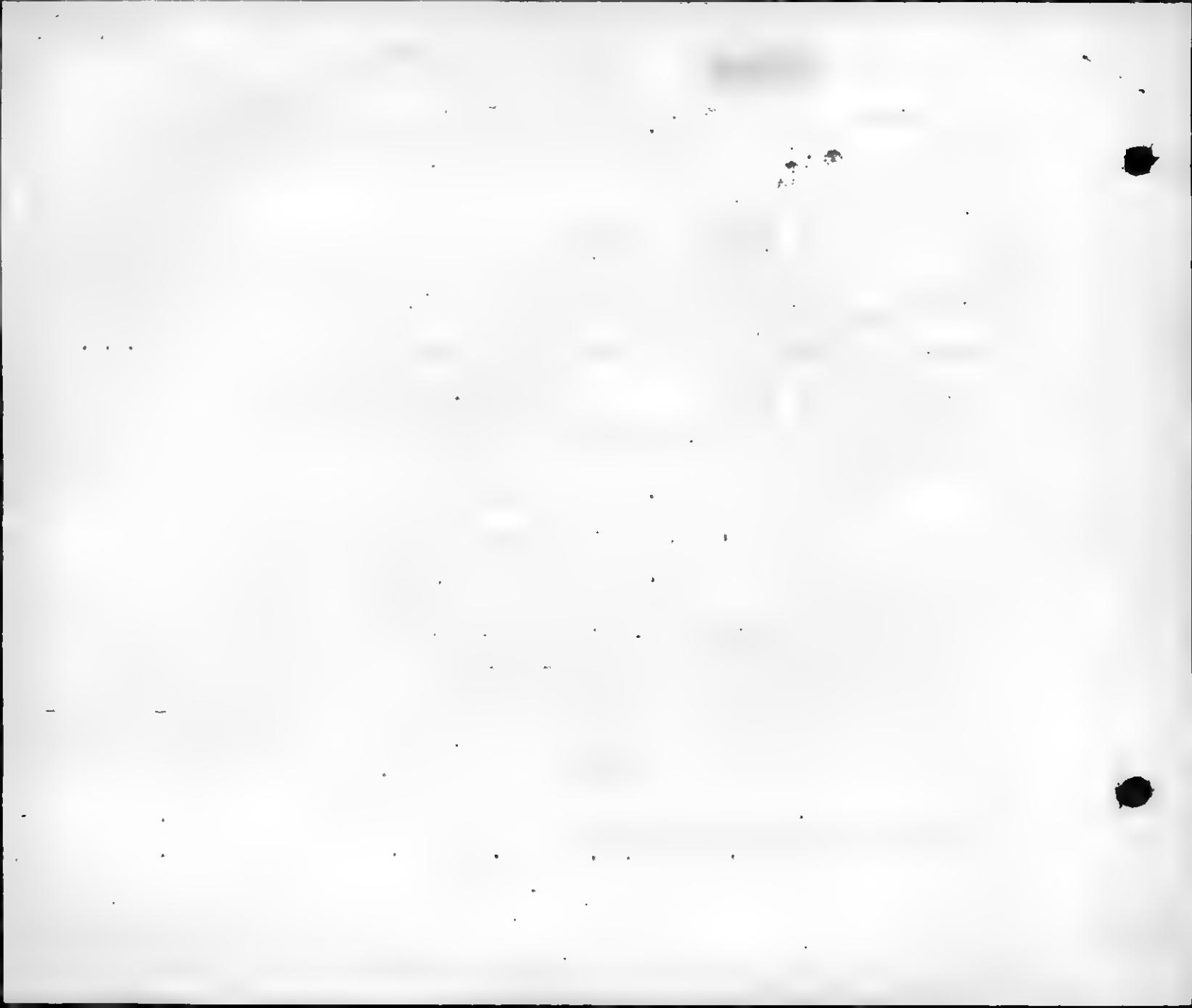


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

12168

**Reg. Dist. No.**

1. PLACE OF DEATH o COUNTY <b>Anne Arundel</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN 1b <b>1 month</b>			a. STATE <b>Maryland</b>			b. COUNTY <b>Harford</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Aire</b>							
3. NAME OF DECEASED (Type or print) <b>Millie Elizabeth Smith</b>			First <b>Millie</b>	Middle <b>Elizabeth</b>	Last <b>Smith</b>	4. DATE OF DEATH <b>11 9 1959</b>	Month <b>11</b>	Day <b>9</b>	Year <b>1959</b>	d. STREET ADDRESS <b>?</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1877 Mar 2nd</b>			9. AGE (in years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS Days <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic House Keeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Daniel Smith</b>			14. MOTHER'S MAIDEN NAME <b>Caroline Hawley</b>			Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>136-26-5532A</b>			INFORMANT <b>Hospital Records</b>			INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b>													
420.1 DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic Arteriosclerotic Cardiovascular Disease</b>													
DUE TO													
(c) <b>Generalized and Cerebral Arteriosclerosis</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----													
20c. TIME OF INJURY Hour a.m. - - - 19 p.m.		Month, Day, Year While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <b>10/9 1959</b> to <b>11/9 1959</b> , that I last saw the deceased alive on <b>11/9 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.													
ACTUAL SIGNATURE <i>Lester McHenry Mapp</i> ADDRESS (Street, city or town, state) <b>M.D. Crownsville State Hospital, Md.</b> DATE SIGNED <b>11/9/59</b>													
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		Crownsville State Hospital, Md. <b>11/9/59</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/12/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist</b>			22d. LOCATION (City, town, or county) <b>Alexandria Maryland</b> (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barnes, Alexandria, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>			24b. REGISTRAR'S SIGNATURE <i>Arthur &amp; Anna</i>						



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12141

## CERTIFICATE OF DEATH

Reg. Dist. No.

12169

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 West Street</u>		d. STREET ADDRESS <u>10 Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 West Street</u>				f. DATE OF DEATH <u>NOVEMBER 17 1959</u>		Month Day Year		
3. NAME OF DECEASED (Type or print) <u>WITASKI</u>		First <u>V</u>	Middle <u>SNYDER</u>	Last <u>?</u>		Month <u>NOVEMBER</u>	Day <u>17</u>	Year <u>1959</u>
4. SEX <u>Female</u>		5. COLOR OR RACE <u>White</u>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? ? , 1880</u>		
9. AGE (In years last birthday) <u>79 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		12. BIRTHPLACE (State or foreign country) <u>Poland</u>		
13. CITIZEN OF WHAT COUNTRY? <u>USA</u>								
14. FATHER'S NAME <u>Unknown</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>						
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>none</u>		18. INFORMANT <u>Morris Snyder- Son- Same as # 2</u>		Address		
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>420.0</u>		20. DUE TO (b) <u>Coronary Thrombosis</u>		21. DUE TO (c) <u>Arterio Sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		26. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 28. (City or town) (County) (State)		
29. I certify that I attended the deceased from <u>Nov. 1, 1959</u> , to <u>11/16/1959</u> , that I last saw the deceased alive on <u>11-16-1959</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED		
30. ACTUAL SIGNATURE <u>James R. Martin</u>		31. PHYSICIAN'S NAME (Type) <u>James R. Martin MD</u>		32. M.D.		33. November 17, 1959		
34. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		35. DATE THEREOF <u>Nov. 18, 1959</u>		36. NAME OF CEMETERY OR CREMATORIAL <u>Kneseth Israel Cemetery</u>		37. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>		
38. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		39. ADDRESS <u>Annapolis, Maryland</u>		40. REC'D BY REGISTRAR <u>NOV 20 '59</u>		41. REGISTRAR'S SIGNATURE <u>Arthur L. Tracy</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12191

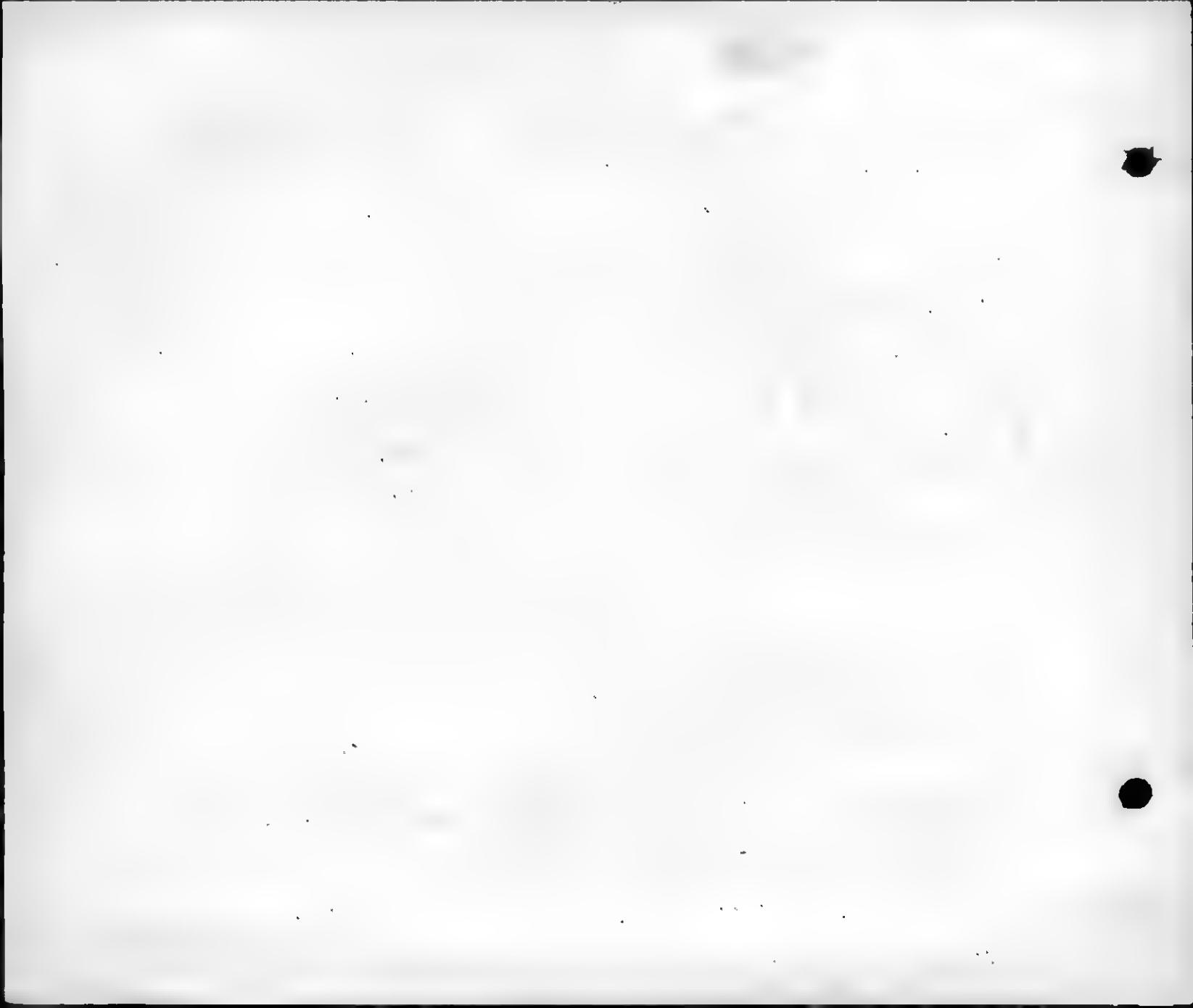
## CERTIFICATE OF DEATH

Reg. Dist. No.

12170

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the physician or attending physician after this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ARNOLD</i>		c. LENGTH OF STAY IN 1b <i>3 YEAR</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10 HARMONY AVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EDITH TIFFANY</i>		First <i>T</i>	Middle <i></i>
4. DATE OF DEATH <i>Nov. 27 1959</i>		Last <i>TARR</i>	Month <i></i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 8 1903</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>N.L.A.</i>	
13. FATHER'S NAME <i>Henry William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>217-05-5303</i>	
17. INFORMANT <i>MR GEORGE L. TARR</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertensive cardio-vascular disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>59</i> , to <i>Nov 27</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>27 Nov 1959</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gene D. Trettin</i>		ADDRESS (Street, city or town, state) <i>M.D 715 COTTER RD GLEN BURNIE MD</i>	
PHYSICIAN'S NAME (Type) <i>GENE D. TRETTIN</i>		DATE SIGNED <i>28 Nov 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 1, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HENRY SANDERSON &amp; SONS INC. BALTIMORE MD</i>		24a. REC'D BY REGISTRAR DATE DEC 2 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kraus</i>	



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13171

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY

ANNE ARUNDEL

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

Annapolis

d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]

2090 Forest Drive

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

LOTTIE

Last

THOMAS

5. SEX

Female Colored

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED  DIVORCED 9. AGE (In years  
last birthday)  
44 yrs.10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

11. M.D. OF BUSINESS OR INDUSTRY

12. COUNTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or details of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

Gunshot wound of right temple

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot self in head

Partial

20c. TIME OF INJURY  
Hour a.m. 8:15  11/13, 195920d. INJURY OCCURRED  
While at work  Not While at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Annapolis (County) Anne Arundel (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. FUNERAL DIRECTOR

W. Bradley King, Jr., M.D.

22c. DATE THEREOF  
11-17-5922d. NAME OF CEMETERY OR CREMATORIUM  
Brewer Hill22e. LOCATION (City, town, or country)  
Annapolis Md. (State)CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 

M.D.

DEPUTY MEDICAL EXAMINER DATE SIGNED  
11/13/59

Address (Street, city, town, or county)

Arthur &amp; Thorne

VS. AT5ME  
5M 7/59

24a. REC'D BY REGISTRAR

NOV 17 '59

25. REGISTRAR'S SIGNATURE

Arthur &amp; Thorne



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

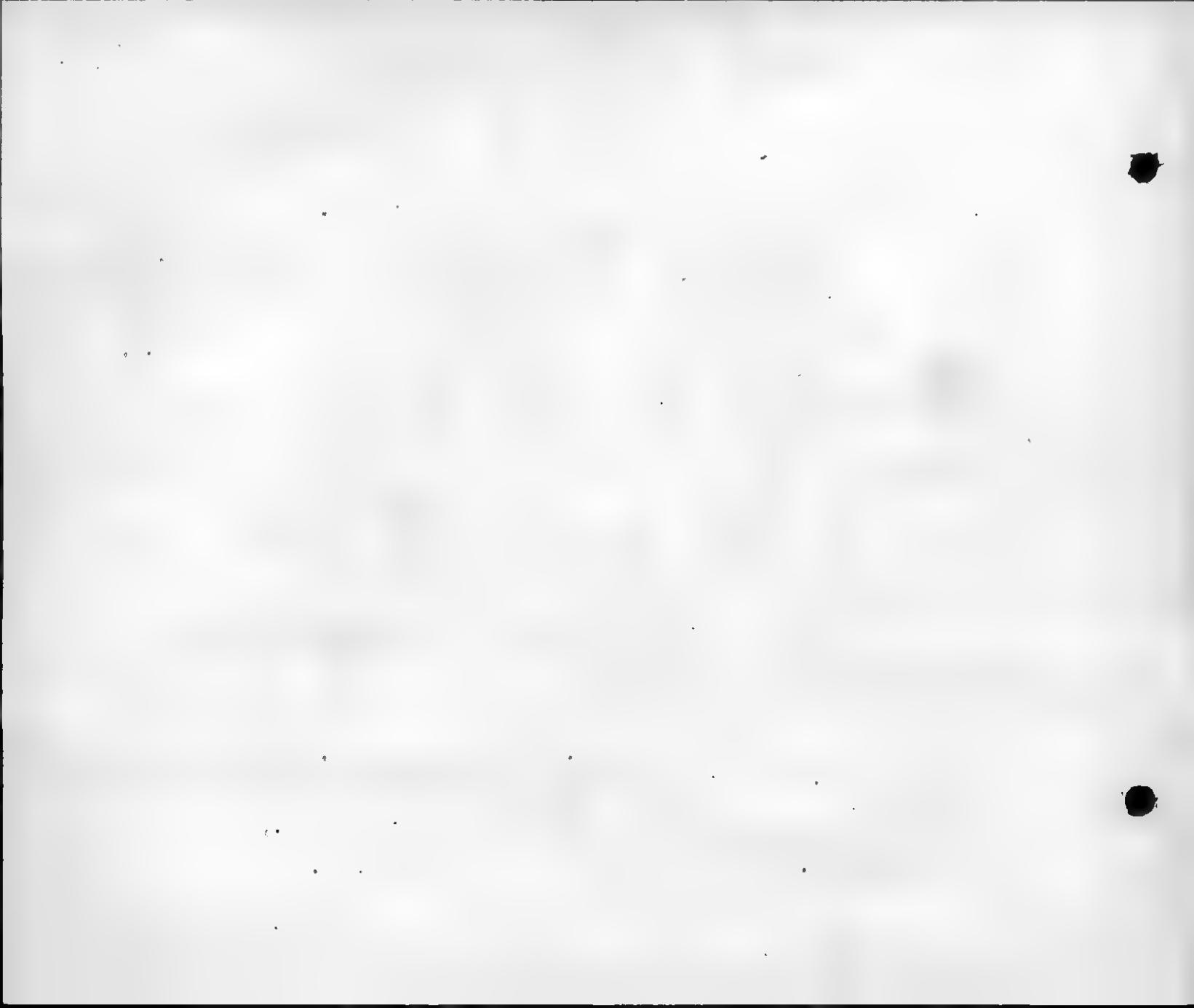
12172

Reg. Dist. No.

12143

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>518 2nd St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Lawrence</b>	Middle <b>R.</b>	Last <b>TUERS</b>	4. DATE OF DEATH	Month <b>November</b>	Day <b>25</b>	Year <b>1959</b>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<b>Male</b>		<b>White</b>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>May 1, 1898</b>	<b>61 yrs</b>	Months <b>61</b>	Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.S. Naval Academy</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Arthur M. Luers</b>		14. MOTHER'S MAIDEN NAME <b>Emma M. Rutter</b>		INFORMANT <b>Viola A. Luers</b>		Address <b>2</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis &amp; myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>								
Conditions, if any, which gave rise to immediate cause (a), striking the underlying cause last. (b) DUE TO <b>Arteriosclerotic coronary art. disease</b> UNKNOWN (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
DIABETES MELLITUS; ESCARLANT VENICES; HEMATURIA cause unknown								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Nov. 20, 1959</b> , to <b>Nov. 25, 1959</b> , that I last saw the deceased alive on <b>Nov. 25, 1959</b> , and that death occurred at <b>10:20 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		<b>11 Southgate Ave., Annapolis, Md.</b>				
ACTUAL SIGNATURE <b>Edward S. Beck</b>		M.D.		<b>11/25/59</b>				
PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>		Annapolis, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 28-59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jahn M. Taylor Sons Annapolis Md</b>		ADDRESS <b>Annapolis Md</b>		24a. REC'D. BY REGISTRAR <b>DEC 1 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Edward S. Beck</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

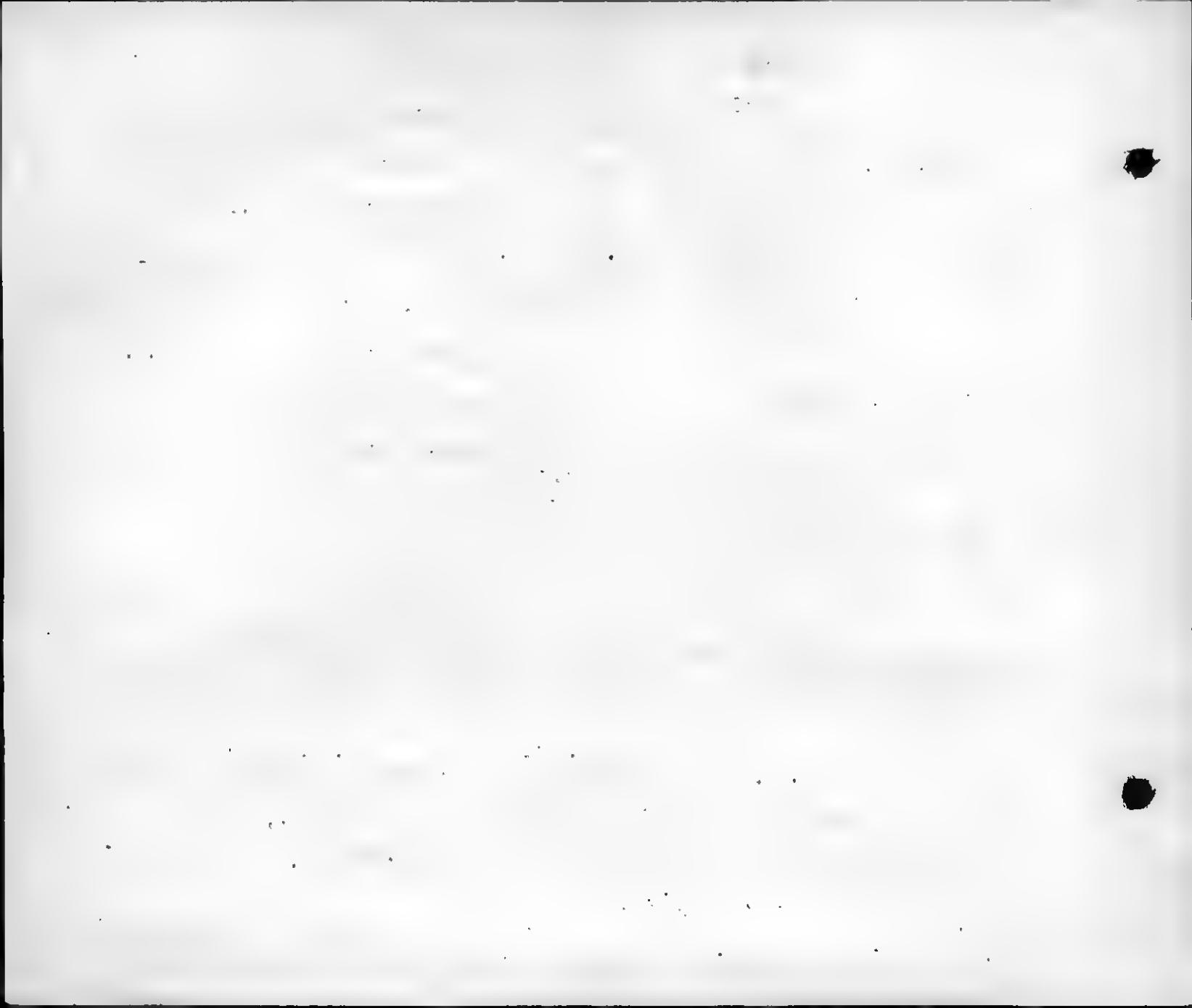
## CERTIFICATE OF DEATH

Reg. Dist. No.

12173

12144

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A. A. Gen. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Edgewater	
3. NAME OF DECEASED (Type or print) Mark		First Allen	Middle VANSOY
4. DATE OF DEATH Last <u>31</u> , <u>1959</u>		Month November	Day 1
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 31, 1959	
9. AGE (In years last birthday) yrs. 72		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Perry Edward VANSOY		14. MOTHER'S MAIDEN NAME Peggy Marie HOAGLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumobesity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 31, 1959, to Nov. 1, 1959, that I last saw the deceased alive on Nov. 1, 1959, and that death occurred at 3:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Edith Rodler</i>		M.D. 45 Franklin St., Annapolis, Md. 11/2/59	
PHYSICIAN'S NAME (Type) Edith Rodler			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-2-59	
22c. NAME OF CEMETERY OR CREMATORIAL HILLCREST		22d. LOCATION (City, town, or county) Annapolis (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor &amp; Son Annapolis, Md.</i>		24a. ADDRESS 24b. REC'D BY REGISTRAR DATE NOV 4 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 File No. 30 11-16-59 et

12174

Reg. Dist. No.

12145

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>503 Burnside St.</b>		d. STREET ADDRESS <b>503 Burnside St.</b>	
3. NAME OF DECEASED (Type or print) <b>GERALDINE</b>		First <b>V.</b>	Middle <b>VODAK</b>
4. DATE OF DEATH <b>11 4 1959</b>	Month <b>11</b>	Day <b>4</b>	Year <b>1959</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1914</b>
9. AGE (In years last birthday) <b>45 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John F. Hirt</b>	
14. MOTHER'S MARRIED NAME (First name unknown) Skrevanek		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)	
16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT <b>Edward M. Vodak #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1958-1959</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Annapolis</b> (County) <b>Hanover</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct 1958</b> , 19 <b>58</b> , to <b>Nov 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 1958</b> , 19 <b>58</b> , and that death occurred at <b>Annapolis</b> , Md., from the causes and on the date stated above. ACTUAL SIGNATURE <b>John M. Taylor</b> PHYSICIAN'S NAME (Type) <b>E. Linhardt</b>		ADDRESS (Street, city or town, state) <b>Annapolis</b> DATE SIGNED <b>Nov 4, 1959</b>	
22a. BURIAL CREMATION: REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-7-1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>ST. MARY'S</b>		22d. LOCATION (City, town, or county) <b>Annapolis</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Son Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 6 '59</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasse</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												
Item 6 Film G253 12/7/59 1wk												
CERTIFICATE OF DEATH												
Reg. Dist. No. 12175												
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. GENERAL Hospital				d. STREET ADDRESS 36 1/2 GLEN AVE								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First THELMA	Middle WESTERVELT	4. DATE OF DEATH		Month 11	Day 22	Year 1959				
5. SEX F		6. COLOR OR RACE IVY White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-1895		9. AGE (In years from birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY SAME			11. BIRTHPLACE (State or foreign country) TROY NY.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EUGENE HYATT			14. MOTHER'S MAIDEN NAME ANNA VAN KIRK			Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.			17. INFORMANT HENRY WESTERVELT						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			Cerebral Circulatory Failure			INTERVAL BETWEEN ONSET AND DEATH 26 Hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO (b)			Carcinoma of Colon (operated)			6 wks			
DUE TO (c)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from APRIL 1959 to NOV 1959, that I last saw the deceased alive on NOV 1959, and that death occurred at 3400 M, from the causes and on the date stated above.									ADDRESS (Street, city or town—state)		DATE SIGNED 12/27/59	
ACTUAL SIGNATURE Edward H. Beck.			M.D. 41 Southgate Ave									
PHYSICIAN'S NAME (Type)			ANNAPOLIS, MD.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-59		22c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN MEM.			22d. LOCATION (City, town, or county) GLEN BURNIE MD.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Son Cremationist			ADDRESS			24a. REC'D BY REGISTRAR NOV 27 '59			24b. REGISTRAR'S SIGNATURE C. E. H. & H. Beck			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192

## CERTIFICATE OF DEATH

12176

Reg. Dist. No.

**TO HOSPITAL OR**  **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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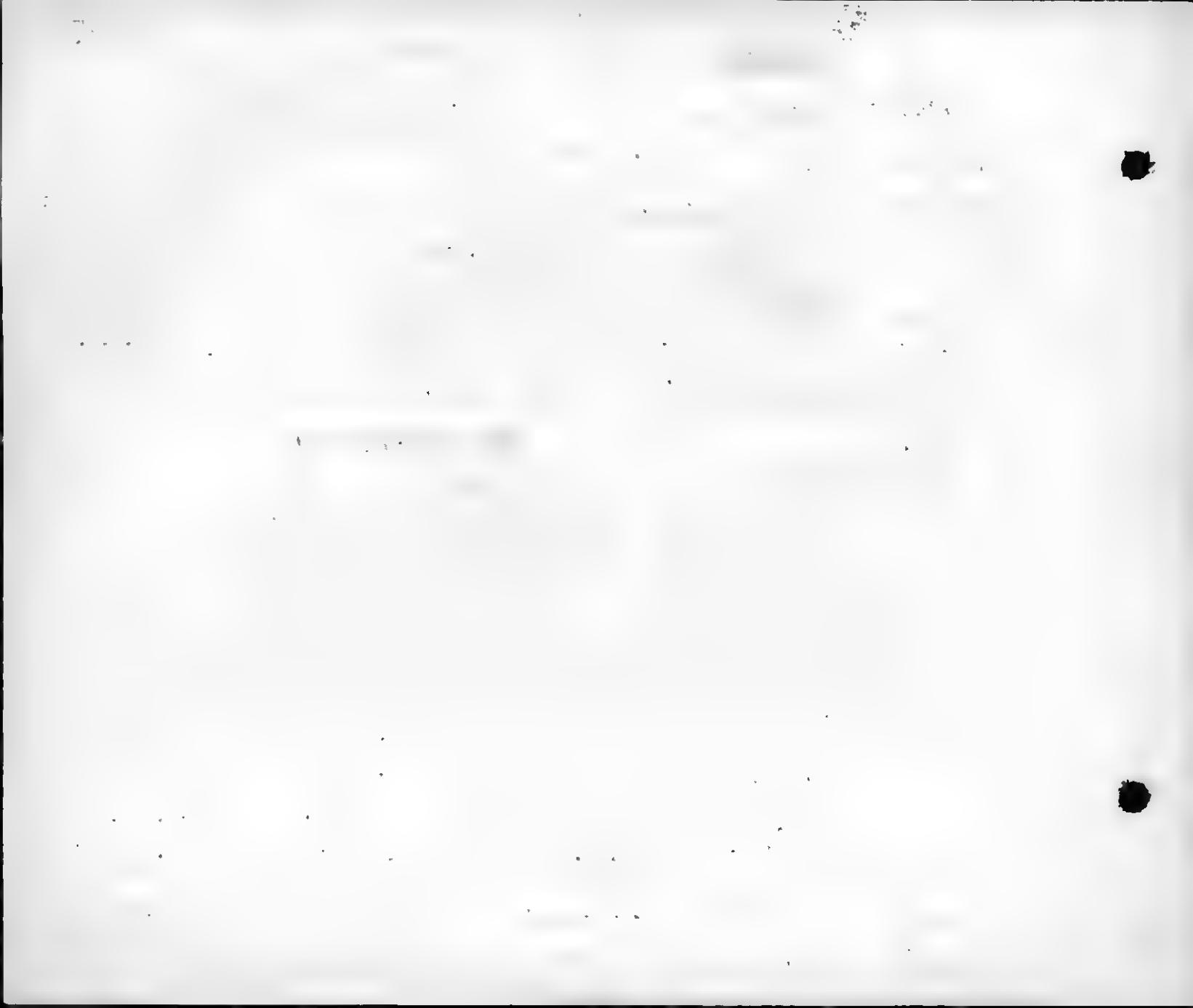
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## MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CROWNSVILLE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH <b>Last 11 Day 17 Year 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
10c. BIRTHPLACE (State or foreign country) <b>Unknown</b>		11. CITIZEN OF WHAT COUNTRY? <b>Maryland U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		18. INFORMANT <b>Medical Records</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Cardiovascular Disease with Aortic Aneurysm of Arteriosclerotic Origin</b>		19. INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <b>Arteriosclerotic Cardiovascular Disease with Aortic Aneurysm of Arteriosclerotic Origin</b>			
DUE TO <b>(b) Aortic Aneurysm of Arteriosclerotic Origin</b>			
DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/10 1959</b> to <b>11/17 1959</b> that I last saw the deceased alive on <b>11/17 1959</b> and that death occurred at <b>12:10A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>11/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		Crownsville State Hospital, Md. 11/17/59	
22a. BURIAL CREMATION: REMOVE <input type="checkbox"/> (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Bruce Hill</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Reese (1) 108 W Washington St</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please sign carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12177

12193

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owingsville</b>		c. LENGTH OF STAY IN 1b <b>14 years 8 mo. 9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marlboro</b>		d. STREET ADDRESS <b>Unknown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Gus</b>	Middle <b></b>	Last <b>Young</b>	4. DATE OF DEATH <b>1889?</b>	Month <b>11</b>	Day <b>21</b>	Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1889?</b>	9. AGE (In years last birthday) <b>70? yrs</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS Days <b></b>	Hours <b></b>	Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure Secondary to Syphilis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarct</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arteriosclerosis - Diabetes Mellitus</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20f. (City or town) -----	(County) -----	(State) -----
20c. TIME OF INJURY Month, Day, Year Hour a. m. — — — p. m. — — — 19		20d. INJURY OCCURRED -----		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20f. (City or town) -----		(County) -----	(State) -----		
21. I certify that I attended the deceased from <b>3/12</b> , 19 <b>45</b> , to <b>11/21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/21</b> , 19 <b>59</b> , and that death occurred at <b>11:10P.M.</b> M, from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Hildegard Heard Reissman, M.D.</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>11/23/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11/23/59</b>		22b. DATE THEREOF <b>11/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. Reissman, Jr.</b>		ADDRESS <b>111 W. Pratt Street, Baltimore, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 27 '59</b>		24b. REGISTRAR'S SIGNATURE <b>W.H. Reissman, Jr.</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147

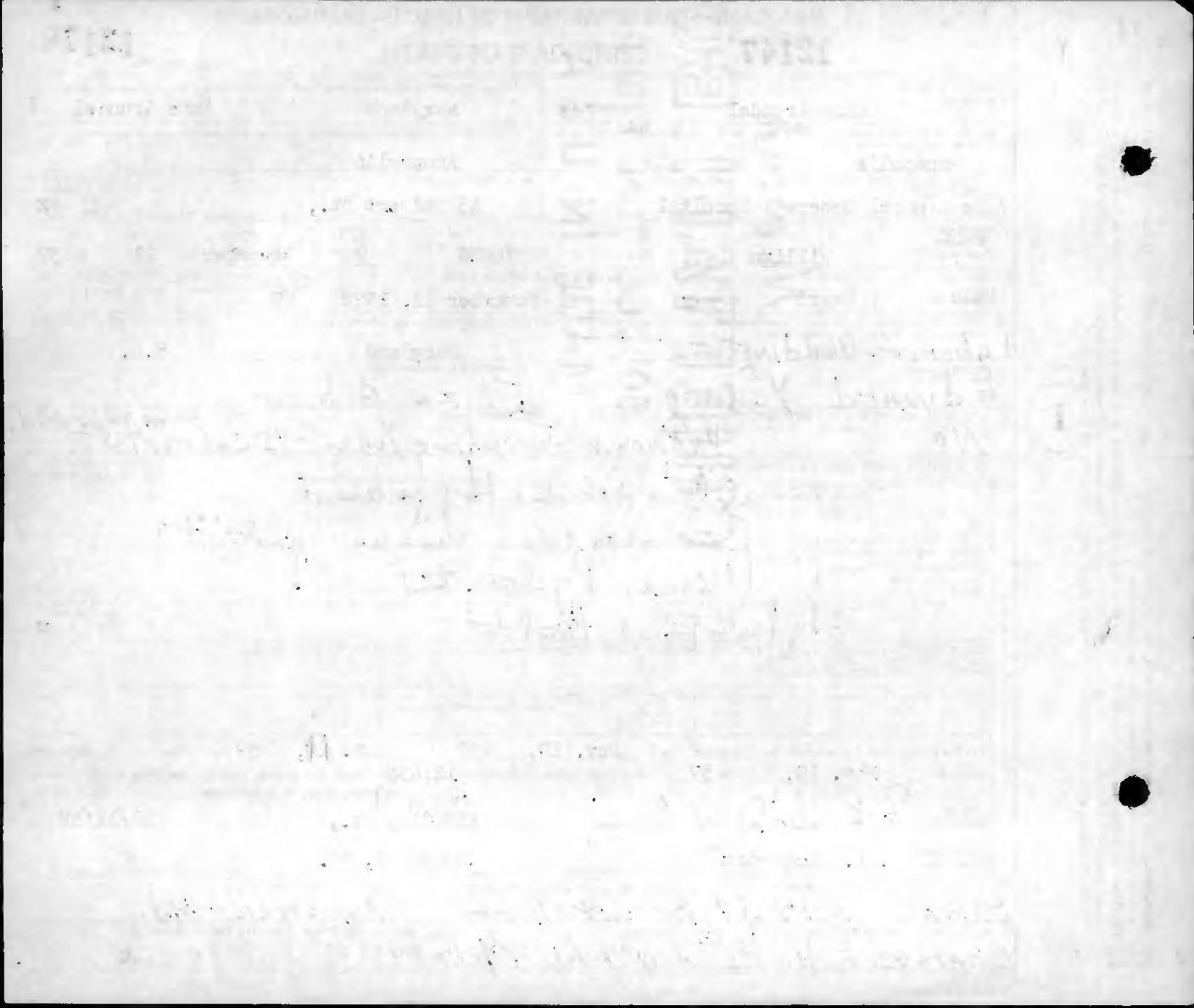
## CERTIFICATE OF DEATH

12178

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>YOUNG</b>	4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 11, 1972</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Building</b>		10b. KIND OF BUSINESS OR INDUSTRY <b> </b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Edward Young</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Gibson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	INFORMANT <b>Josephine Young - 45 Calvert St.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Gastroenteritis</b> <b>Cardiovascular disease</b> <b>Hepatitis</b> <b>Urinary Pyelonephritis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hyperthyroid condition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b> </b>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 10, 1959</b> to <b>Nov. 10, 1959</b> , that I last saw the deceased alive on <b>Nov. 10, 1959</b> , and that death occurred <b>12:45 AM</b> , from the causes and on the date stated above.		DATE SIGNED <b>NOV 11 1959</b>	
ACTUAL SIGNATURE <b>R. L. Richardson</b>	M.D. <b>110 Clay St.,</b>		<b>11/11/59</b>
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>	Ann Arbor, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-14-59</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Brewer Hill</b>	22d. LOCATION (City, town, or county) <b>ANNApolis - Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES E. HICKS</b>	ADDRESS <b>ANNApolis - Md.</b>	24a. REC'D BY REGISTRAR DATE <b>NOV 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Carrie &amp; Krause</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12194

## CERTIFICATE OF DEATH

12179

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY <i>312 Broadway Blvd Glen Burnie</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md</i>		c. LENGTH OF STAY IN 1b <i>10 years.</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION		e. STREET ADDRESS <i>312 Broadway Blvd.</i>	
3. NAME OF DECEASED (Type or print) <i>William Henry Bellman</i>		First <i>William</i>	Middle <i>Henry</i>
4. DATE OF DEATH <i>Nov. 8 1959</i>		Month <i>Nov.</i>	Day <i>8</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec 19, 1871</i>		9. AGE (In years last birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm. (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Hanover Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jacob Louis - Bellman -</i>		14. MOTHER'S MAIDEN NAME <i>Lena - Wenzel -</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Mrs. Adeline Lazarus</i>		Address <i>312 Broadway Blvd Baltimore</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 weeks</i>	
Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last. (b) <i>Cardio. Vascular Disease</i>		4 years	
DUE TO (c) <i>-</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 1</i> , 19 <i>59</i> , to <i>Nov. 8</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov. 9</i> , 19 <i>59</i> , and that death occurred at <i>12:20 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>108 Center on Hudson St</i>		DATE SIGNED	
ACTUAL SIGNATURE <i>James S. Bellmeyer</i>			
PHYSICIAN'S NAME (Type) <i>James S. Bellmeyer Jr.</i>		108 Center on Hudson St	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-11-59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. JOHNS LUTHERAN PEELIFFERS CORNER MD.</i>
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. HIGGINBOTHOMY EWCOTTF City Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Cuthbert &amp; Krause</i>

